

“Held up against each other”

A Qualitative Grounded Theory Investigation into Families’

Experiences of Receiving Behavioural Family Therapy

for Psychosis

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I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification

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ABSTRACT

Psychosis is a complex and distressing condition for everyone whose life it affects, both sufferers and their families. There is a long tradition of theorising about the role of the family environment in the development and maintenance of psychosis and in response to this psychoeducational family interventions such as Behavioural Family Therapy (BFT) (Falloon *et al.*, 1982) have been developed. Research on BFT has focused on the clinical outcomes showing reduced relapse and hospitalisation rates. However, very little is known about the impact of BFT on the families.

The present study aims to gain a deeper understanding of the experience and processes involved in BFT from the perspective of individuals who have received it. A qualitative approach using constructivist grounded theory was used to analyse the experiences of 15 individuals from five families.

The analysis generated three core categories: 'conflict and problem management', 'family togetherness', and 'therapeutic elements'. With reference to the literature on the impact of family environments on psychosis, three inferred results are presented concerning the shared experiences of key persons and family members, perceived outcomes of BFT and processes involved within BFT. A hypothesized model of the mechanisms involved in BFT is presented. Implications of the results for both theory and practice are explored in the discussion.

1. INTRODUCTION

1.1 OUTLINE OF THESIS

Although there has been considerable debate about the effectiveness of Behavioural Family Therapy (hereafter referred to as BFT) there has been comparatively little research into the experience of families who have received this intervention. This thesis examines the experiences of both individuals with psychosis (key persons) and members of their families, in an attempt to identify and better understand the dynamics and impact of BFT from the perspectives of BFT recipients. The thesis is structured in four sections, which are outlined below.

Introduction

The introduction section sets out the key concepts and debates related to BFT and is divided into five sub-sections: first, an overview of psychosis from a bio-psychosocial perspective; second, a review of the research on the interaction between family environments and psychotic illness which has provided the theoretical basis for the development of family interventions; third, a review of the current literature concerning the effectiveness of family interventions for psychosis; fourth, a description of the main principles and techniques of BFT; and fifth, the rationale and aims of the present study.

Methodology

The methodology section outlines the design and procedure used in this study, explains the

rationale for the chosen methodology of constructivist grounded theory and presents a description of the procedural steps taken within this study. Ethical considerations and issues relating to ensuring quality in qualitative methods of enquiry will also be discussed.

Results

The results section is presented in three subsections: a description of participants' family contexts, descriptive results and inferred results. The descriptive results present the main findings of this study. Three core categories of participants' experiences of having received BFT were generated from the data analysis: 'conflict and problem management', 'family togetherness' and 'therapeutic elements'. Each core category is discussed using quotations from participants' narratives as illustrations.

The inferred results present an analysis of the descriptive results in relation to the literature base. Three inferred results are presented: shared experiences within the family unit, perceived outcomes of BFT and perceived processes within BFT. This is followed by a hypothesized model of the mechanisms involved in BFT.

Discussion

The discussion section addresses the implications of the study findings relating to both theory and clinical practice. It also includes a reflective analysis and highlights some of the limitations of this research.

1.2 UNDERSTANDING PSYCHOSIS

This subsection contextualises the illness of the 'key persons' defined in this study as the individuals with a diagnosis of psychosis. Although there have been substantial advances in our understanding of psychosis and its presentation, the development of diagnostic classification systems have not provided clear indicators of treatment prognosis (Bentall *et al.*, 1988).

1.2.1 Diagnostic classifications of functional psychotic disorder

Schizophrenia were first termed as 'dementia praecox' by Kraepelin (1919) who first reported on the distinguishing symptoms from other psychiatric disorders such as thought affective dysfunction and psychological and motor impairment (Barrowclough & Tarrier, 1997).

Bleuler (1911) challenged Kraepelin's ideas and replaced the term dementia praecox with the term *schizophrenia*, meaning 'split mind' in Greek. He placed emphasis on the cognitive processes in the disorder, in particular looseness of cognitive associations. His conceptualisation of the disorder and classification of primary and secondary symptoms formed the basis of the modern diagnostic system (Barrowclough & Tarrier, 1997).

Diagnostic classification systems have sought to distinguish between psychotic syndromes with an underlying organic cause and psychotic syndromes where no obvious organic cause can be identified, understood as 'functional psychoses' (Fowler *et al.*, 1996). Functional

psychoses encompass three main syndromes: schizophrenia, affective psychosis and delusional disorders (Fowler *et al.*, 1996).

In its modern use, schizophrenia refers to functional psychotic syndromes in which the characteristic symptoms are hallucinations and delusions, and symptoms associated with significant social decline. The current term 'affective psychosis' refers to psychotic syndromes characterised by the affective component of symptoms associated with depression or mania and finally, delusional disorders now refer to psychotic syndromes involving delusional beliefs without accompanying hallucinations such as persecutory or paranoid beliefs (Barrowclough & Tarrier, 1997).

However, there are not clear distinctions between 'schizophrenia' and 'affective psychosis' in the current classification. A significant minority of individuals present a combination of affective and non-affective psychotic symptoms (Brockington *et al.*, 1978; Kendall & Gourlay, 1970) and over time there can be changes in the presentation of an individual's symptoms which may affect criteria for classification (Brockington & Meltzer, 1982). There is also no consensus regarding the ability of classification systems to account for the underlying process in schizophrenia (Fowler *et al.*, 1996).

Despite these limitations, diagnostic classifications represent significant clinical developments in enabling clinicians to diagnose, provide effective treatment and study and compare individuals with psychiatric disorders (Fowler *et al.*, 1996).

The most current diagnostic classification systems, namely the Diagnostic Statistical Manual, fourth edition (DSM-IV) (American Psychiatric Association, 1994) and the International Classification of Diseases (ICD-10) (World Health Organisation, 1992), represent further developments from earlier classification systems in line with the research in successfully identifying individuals who share the core presentations (Fowler *et al.*, 1996).

1.2.2 Symptoms

DSM-IV defines schizophrenia as a persistent, chronic and affecting a variety of aspects of behaviours, emotions and cognitive processes in which two (or more) of the following symptoms are present for a significant portion of time during at least a one month period: hallucinations, delusions, incoherent or marked looseness of association, as well as catatonic behaviour, affective flattening, alogia or avolition (American Psychiatric Association, 1994). Symptoms have been clustered into two groups: positive symptoms and negative symptoms.

Positive symptoms are deemed to add to or exceed a person's 'normal' personality characteristics and include hallucinations, delusions, incoherent and thought disorder. It has been suggested that approximately two thirds of sufferers experience auditory hallucinations and approximately one tenth of sufferers report hallucinations of smell, taste and touch (Barrowclough & Tarrier, 2001). Thought disorder can involve beliefs about thought insertion where sufferers experience thoughts not recognised as their own and thought broadcasting where sufferers believe their thoughts are audible to others. Delusional ideas such as persecutory delusions of reference, grandeur and control are also reported (Barrowclough & Tarrier, 2001).

Negative symptoms, in contrast to positive symptoms, refer to deficits in functioning: for example, flatness or inappropriate emotions, reduced levels of enjoyment, poor motivation, activity and concentration and social withdrawal (Barrowclough & Tarrier, 2001). Fowler and colleagues (1996) highlight that negative symptoms (even in the absence of positive systems) can cause the more distress to relatives.

1.2.3 Vulnerability-stress model of psychosis

There is evidence for the influence of biological factors on psychotic disorders (Birchwood *et al.*, 1988; Frith, 1992; Kerwin, 1992) however, the traditional disease model originally proposed by Kraepelin (1919) does not provide a full explanation of all manifestations of schizophrenia in terms of a discrete biological syndrome (Hall *et al.*, 1994; Janzarik, 1987). A few theorists go even further and argue that psychoses are social constructs rather than disease entities with an underlying biological cause (e.g. Boyle, 1990; Laing, 1965).

Barrowclough and Tarrier (2001) suggested that the impact of vulnerability-stress models of psychotic illness cannot be underestimated as they provide a framework to assist in the understanding of psychosis as a complex illness with biological, psychological and social contributing factors. Vulnerability-stress models of psychosis share the key assumption that 'vulnerability' and 'stress', and in particular their interaction, are important in both the development and relapse of psychotic episodes (Lieberman, 1982; Mueser & Glynn, 1999; Nuechterlein & Dawson, 1984; Zubin & Spring, 1977).

The models describe the interactions between 'vulnerability' or genetic predispositions and precipitating external events 'stressors' as underlying causes of both the positive and negative symptoms of schizophrenia (Zubin & Spring, 1977). A shortcoming of these models is that they focus predominantly on the positive symptoms and do not provide a full explanation of the development of negative symptoms. The role of vulnerability and stress as factors in schizophrenia are discussed below.

The term 'vulnerability' was conceptualized by Zinger and Spring (1977) as predispositional factors that can contribute to the development of schizophrenia. Early vulnerability-stress models indicated that vulnerability was due only to biological or genetic factors. However, the understanding of the 'vulnerability' concept has now been advanced to include a wider range of possible underlining factors such as psychological factors, information processing dysfunction and interpersonal difficulties (Monroe & Simons, 1991).

Some theories describe stress and vulnerability as separate factors in the development of schizophrenia. The contributing role of stress in the development, maintenance and relapse of mental disorders is well accepted (Ingran & Luxton, 2005; Meehl, 1962; Rosenthal, 1963). Meehl (1962) theorised that certain individuals have a vulnerability of a 'schizotypic' personality. However, the development of schizophrenia cannot solely be attributed to a 'schizotypic' personality and the experience of environmental stressors are necessary to trigger schizophrenia. Within his theory, he pinpointed the negative interactions with a 'schizophrenogenic' mother as a key contributor to increased stress and described her as is 'ambivalent' and 'inconsistently aversive'.

Meehl (1962) argued in his first theory that the environmental stressor could not lead to schizophrenia in the absence of a 'schizogene'. However, in his revised later model 'SHAITU' (Meehl, 1989; 1990) he defined a pathway that did not require the 'schizogene' to be present in the development of schizophrenia. This pathway is summarized in the SHAITU acronym, where SHAI refers to four personality traits (submissive, hypohedonic, anxious, introverted), 'T' refers to environmental risk factors during development and 'U' refers to unlucky events or environmental risk factors in adult life (Ingran & Luxton, 2005).

Threshold models (Monroe & Simons, 1991; Rothman, 1976) suggest that diathesis (disposition) and stress have a synergistic effect, where stress is not independent from vulnerability but rather an integral part of it. Zubin and Spring (1977) proposed a linear threshold model, where genetic or biological vulnerability represents a threshold to the onset of schizophrenia.

Zubin and Spring's (1977) model stipulates that as an individual's level of stress increases, the level of risk of developing schizophrenia also increases. The amount of vulnerability is seen to directly effect the level of environmental stressors needed to cross the threshold of becoming unwell, where the greater the level of an individual's vulnerability, the less stress is needed to cross the threshold. Within this, the level of vulnerability also affects the appraisal of environmental factors as stressful and so the model is understood as the interaction between vulnerability and stress (Barrowclough & Tarrier, 2001).

The linear threshold model has been criticised as simplistic since it lacks a clear explanation of the nature of stress and vulnerability, and suggests an 'all or nothing', well or unwell presentation of illness which often does not correlate with clinical presentations (Barrowclough & Tarrier, 2001).

A further vulnerability-stress model has been proposed by Mueser and Glynn (1999) which incorporated protective factors as a third competent in explaining the development of schizophrenia. Their model identified protective factors such as medication or therapy as a tool to buffer and protect against vulnerability and stress factors.

These models have particularly clear advantages for the understanding of the episodic nature of schizophrenia and provide a useful framework for psychological interventions due to their emphasis on the role of the social environments (Barrowclough & Tarrier, 2001). They imply that changing or reducing the level of environmental stressors for an individual would act to reduce the risk of developing schizophrenia and importantly would also act to

reduce the risk of relapsing for individuals who have experienced past psychotic episodes. This supposition has been the driving force behind the development of the family interventions for psychosis where enhancing supportive and positive family environments are viewed as protective factors to reduce or buffer against environmental stressors (Barrowclough & Tarrier, 2001).

1.3 FAMILY ENVIRONMENTS

1.3.1 The role of the family in psychosis

Onset and relapse of psychosis is a distressing life event with negative emotional and psychological consequences for both the individual and their family (Gumley & Schwannauer, 2006). Negative consequences of relapse have been shown to include social disability (Hogarty *et al.*, 1991), high levels of stress for family members (Barrowclough *et al.*, 2001) and an increase in residual symptoms after acute psychotic episodes (Wiersma *et al.*, 1998).

Vulnerability-stress models point to several areas in which the family can play an important role in improving the outcome in psychosis. However, the role of the family is not explicitly emphasised within these models. What is implicit within the vulnerability-stress models is that the family can have an important role in building up protective factors against relapse, to use Mueser and Glynn's terminology. It is within the double bind theory

(Bateson *et al.*, 1956) and the expressed emotion (EE) constructs (Brown & Rutter, 1966) that the role of the family in schizophrenia is explored directly.

A number of early theories proposed the concept of the 'schizophrenogenic family' and interpreted schizophrenia as a reaction to a dysfunctional family environment. Fromm-Reichmann (1948), a precursor of Meehl, hypothesized that a mother's behaviour can generate psychosis in a child. He introduced the term 'schizophrenogenic mother' and described her behaviour as 'rejecting', 'rigid' and 'impervious' (Fromm-Reichmann, 1948).

Dysfunctional communication patterns within families have been considered a cause for both the onset and relapse of schizophrenia. Models of dysfunctional communication include the transactional disqualification (Sluzki *et al.*, 1967), pseudomutuality (Wynne *et al.*, 1958), scapegoating (Ackerman, 1958), double bind theory (Bateson *et al.*, 1956) and communication deviance (Singer & Wynne 1965; 1966). Double bind theory and communication deviance are the two most relevant dysfunctional communication patterns for this present study.

1.3.2 Double bind theory

The most popular and highly controversial theory from early research is the double bind theory (Bateson *et al.*, 1956). Bateson and colleagues attributed schizophrenia symptoms to contradictions in communicative processes within the family. They proposed that if a mother gives contradictory messages to her child without the contradictions being explicitly

understood, the child's ability to communicate can be disrupted and this can become a factor in the development of schizophrenia.

Bateson and colleagues (1956) provide an example of a double bind interaction with a mother and schizophrenic child, where the child attempts to embrace their mother and she responds by stiffening her body whilst in the same interaction telling the child not to be embarrassed about showing their feelings, thereby producing conflicting verbal and non-verbal messages. They argued that because of a child's dependence on their mother, this incongruent communication prevents the child from communicating effectively.

One of the difficulties with the double bind construct is its reliance on the evaluation of family communications by a third party. Outsider observers may perceive many verbal and non-verbal communication messages as incongruent when these messages may hold meaning and congruence within the family unit (Mishler & Waxler, 1965). A further criticism relates to the fact that siblings who are witness to the same communication patterns as the individual with schizophrenia often do not develop the same symptoms. The strong claims of the double bind theory have also been criticized as attributing responsibility and blame on to the mother. Nevertheless, it is important to remark that this is one of the theoretical foundations of family intervention.

1.3.3 Communication deviance

Singer and Wynne's research identified a communication pattern termed 'communication deviance' characterised by a lack of clarity in communication between parent and child (Singer & Wynne 1965; 1966). They argued that frequent communication disruptions can prevent the parent and child from developing a shared understanding of discourse. In contrast to the double bind theory that requires full contradictions within communication (for example between verbal and non verbal communication), 'communication deviance' refers to interactions that may have some congruent aspects of communication but are more generally interpreted as confusing and unclear.

Singer and Wynne (1965; 1966) argued that children with schizophrenia were likely to be more sensitive than siblings to communication patterns of parents and therefore be adversely affected. Communication deviance theory has been criticized for lacking robust empirical evidence and shares the weaknesses of the double bind theory in that it relies on observers' evaluation of the level of an individual's understanding of a family interaction and has produced negative connotations for blaming the family in their role of illness.

1.3.4 Expressed emotion

The concept of 'expressed emotion' (EE) is the dominant concept in current literature underlying the development of family interventions. Research into EE has demonstrated that family environments and in particular family interactions characterised by high levels of EE are a predictor of relapse (Brown & Rutter, 1966). Three main EE components have

provided an explanation of behaviour and communication patterns of families' or significant others' towards the individual with schizophrenia. First, 'criticism', primarily critical comments; second, 'hostility' and rejection; and third, 'emotional over-involvement' (EOI). The latter is probably the most complex response as it involves a number of different behaviours including exaggerated emotional response, self-sacrifice and extreme over-protectiveness. Although EE is commonly understood as a set of negative responses, a further construct introduces 'warmth' and positive comments as a fourth component.

EE as a factor in relapse

Two influential studies by Brown and colleagues (1972) and Vaughn and Leff (1976) provided the first evidence that patients living with high EE families (i.e. families with high levels of criticism, hostility and/or EOI) showed a greater rate of relapse than patients living with low EE families. From this a strong body of research has continued to show correlations between high EE families and psychotic relapse (e.g. Linszen *et al.*, 1996; Nuechterlein *et al.*, 1992; Tanaka *et al.*, 1995; Tarrier *et al.*, 1988; Vaughn *et al.*, 1984; 1992).

Kavanagh (1992) conducted a review of 23 studies conducted across 12 countries investigating family levels of EE and rates of relapse. At 12 months, 20 out of the 23 studies found a greater rate of relapse in high EE families (median relapse rate of 48 per cent) compared to low EE families (median relapse rate of 21 per cent). Kavanagh reviewed four studies that investigated relapse rates at two years follow-up and again

showed a higher rate of relapse in high EE families (median rate of 61 per cent) compared to low EE families (median rate of 27 per cent).

It has been proposed that there is also an association between families' beliefs and attributions about the causes of illness and the individual's risk of relapse. Barrowclough and colleagues (1994) found that relatives with high levels of criticism and hostility made more personal and controllable attributions regarding the behaviour of the individual with psychosis, whereas relatives with low levels of criticism and hostility, and relatives with high levels of EOI were found to make more non-personal and uncontrollable attributions regarding the behaviour of the individual.

Results of a more recent study by Barrowclough and Hooley (2003) suggested a link between high EE families and a higher level of positive symptoms experienced by the individual. This study also investigated the individuals' self-evaluation and proposed that higher levels of negative self evaluations were also associated with increased positive symptoms.

Controversy

There is still significant controversy about both the nature of EE and its effects on relapse rates. Research on EE shares the same criticisms of the early communication dysfunction theories (Bateson *et al.*, 1956; Singer & Wynne, 1965; 1966) for its potential interpretation of placing blame on families for an individuals' illness.

Some research has indicated no clear correlation between levels of EE and psychotic relapse (Kottgen *et al.*, 1984; Parker *et al.*, 1988; Patterson & Birchwood, 2005; Stirling *et al.*, 1991). There is also dispute over the causes of EE and whether high EE is a cause of relapse in schizophrenia or a reflection of the difficulties encountered by families living with an individual with schizophrenia. Cheng (2002) suggests that a distinction needs to be made about the onset of EE characteristics, suggesting that EE should be viewed as either pre-existing in families prior to the onset of schizophrenia or as a reaction to the development of illness.

Patterson and Birchwood (2005) consider that it would be 'abnormal' for family members to react to the onset of psychosis in a relative with low levels of EE and argue that EE is an unstable characteristic with fluctuations over time. They claim that family members perceive the onset of psychosis as a loss and go on to argue that coercive criticism is a natural reaction to this perceived loss.

The positive EE construct of warmth has received relatively little attention but it is possible that levels of warmth within a families are as important as criticism, hostility and EOI in evaluating family environments. Evaluating the role of family warmth may act as a counterbalance to the emphasis placed by past research on the dysfunctional family.

1.3.5 Carer burden

Research on the concept of carer burden has mainly focussed on defining the meaning of the concept (Biegel *et al.*, 1994; Gubman *et al.*, 1987; Loukissa, 1995; Reinhard & Horwitz, 1995; Rose, 1996; 1998). One common understanding of carer burden is described as the level of burden a carer feels due to them placing the needs of the ill relative before their own (Clausen & Yarrow, 1955).

The experience of caring for a ill relative has been found to generate beneficial emotions and a positive self-image (Rose & Horwitz, 1995). However, the concept of carer burden encompasses negative aspects of the experience of families with one member suffering from schizophrenia and has been argued to show resemblances to the emotions and experiences associated with grief (Atkinson, 1994; Eakes, 1995). Grief in this context has been understood as 'permanent, periodic and potentially progressive in nature' (Eakes, 1995, p78).

Phelan (1998) study found that fifty per cent of parents or spouses whos relative has recently been admitted to a psychiatric hospital had concealed the hospitalisation to others outside the family. Doka (1989) described this as a form of 'disenfranchised grief' as the decision of family members not to disclose an individual's illness would make it difficult for them to reach closure or gain support for the stressful life event. This 'disenfranchised grief' could also reduce family members ability to react in an appropriate or positive manner towards the individual suffering from schizophrenia (Doka, 1989).

The most important indicator of carer burden as been shown to be the subjective appraisals of a family member's level of burden felt (Coyne, 1987; Jones *et al.*, 1995; Reinhard & Horwitz, 1995). The amount of negative burden experienced by carers has been attributed to many interacting factors. Increased levels of burden have been found where carer live with the ill relative compared to carers living away from the relative (Jones *et al.*, 1995). Other factors have shown the quality of the relationship between the carer and ill relative and the age of the carer as important (Cook *et al.*, 1994) and this has been further linked to variations in ethnicity of families (Reinhard & Horwitz, 1995). Jones and colleagues (1995) reported that high levels of carer burden were found be associated with families that perceived the ill relative's behaviour negatively such as disruptive or demanding behaviour.

1.4 FAMILY INTERVENTIONS

1.4.1 Growing interest

Interest in psychoeducational family interventions for schizophrenia has grown over the last 30 years, based on EE research suggesting that living with high EE families increased the risk of psychotic relapse (Brown *et al.*, 1972). Interest is highlighted by the growing number of research and clinical trials published: Lam (1991) reviewed six studies, Dixon and Lehman (1995) reviewed 15 studies, Pharaoh and colleagues (1999) reviewed 13 studies, Pitschel-Walz and colleagues (2001) undertook a meta-analysis of 25 studies, Falloon (2003) reviewed 25 studies, and most recently the meta-analysis by Pharaoh and colleagues (2007) reviewed 43 studies.

Fadden (1998) suggested that the increased popularity in these interventions is due to three factors: increased focus on evidence-based practice, financial considerations creating pressure to use cost-effective interventions and the growing influence of service user involvement.

Clinical trials on the effectiveness of psychoeducational family interventions have shown to be effective in clinical and social outcomes when pharmacotherapy is combined with family interventions (cf. Dixon & Lehman, 1995; Falloon, 2003; Pharaoh *et al.*, 1999; Pharaoh *et al.*, 2007). Nevertheless, questions remain over the degree of their effectiveness. The next section reviews some of the research into the effectiveness of family interventions.

1.4.2 Comparing research studies

The research on family therapy has produced a large number of studies over the last 30 years. Common to most studies is the inclusion of patients with a diagnosis of schizophreniform, schizophrenic or schizoaffective psychoses (Pharaoh *et al.*, 2007) and the introduction of family interventions follows hospitalization or remission of the acute psychotic symptoms (Falloon, 2003).

However, it is important to emphasise that comparisons between studies is difficult due to the considerable variation in the use of terminology, specific strategies used, duration of interventions and outcome measures (Fadden, 1998). Some studies were limited to

providing only drug treatment information (Atkinson *et al.*, 1996; MacCarthy *et al.*, 1989; Posner *et al.*, 1992; Zhang *et al.*, 1998) whilst other studies incorporated several strategies, for example social skills training (Hogarty *et al.*, 1986), motivational interviewing (Barrowclough *et al.*, 2001), 24 hour support for the family (Falloon *et al.*, 1981), and relaxation training (Hogarty *et al.*, 1997).

1.4.3 Methodological problems with research

Common criticisms of all research on psychosocial interventions include the risk of observer bias associated with not blinding raters (Pharaoh *et al.*, 2007), as well as the involvement of participants who cannot be blind due to the nature of the interventions (Falloon, 2003). A further difficulty relates to the definition of 'relapse', which is inconsistent across studies (Falloon, 2003; Pharaoh *et al.*, 2007). Some studies required readmission into hospital to qualify as relapse, whilst others required the re recurrence of symptoms ranging from deterioration of symptoms to full recurrence of symptoms compared to the baseline measurements (Pharaoh *et al.*, 2007).

1.4.4 Evidence base for psychoeducational family interventions

Psychoeducational family interventions are aimed at reducing the risk of relapse by reducing environmental stresses within the family and promoting social functioning of both the psychotic individual and the family (Falloon, 2003).

There are three main types of family interventions (Fadden, 1998). The first based on behavioral theory, aims to improve problem solving within the family (Falloon *et al.*, 1984) and generally involves the patient and their family. The second type of family interventions are primarily focused on the needs of family members and do not involve the patient. Falloon (2003) suggest that these interventions primarily aim to increase family support (e.g. MacCarthy *et al.*, 1989; Szmukler *et al.*, 1996) and reduce carer stress associated with caring for the patient (e.g. Anderson *et al.*, 1986; Leff & Vaughn, 1985). Both types of interventions generally involve acquisition of skills and didactic components (Fadden, 1998). Finally, the third type of family intervention is based on systemic family approaches focusing on relationships and the wider social context of the family (reviewed in section 1.4.5)

Relapse

Four groups of influential psychoeducational studies, Falloon and colleagues (1982, 1984, 1985); Hogarty and colleagues (1986, 1991); Leff and colleagues (1982, 1985, 1989) and Tarrier and colleagues (1988; 1989) contributed substantially to the clinical developments in this area (Fadden, 1998). The results from these studies produced the initial evidence for the effectiveness of psychoeducational interventions compared to standard psychiatric treatment.

Of particular interest to this present study is the research by Falloon and colleagues (1982, 1984, 1985), who compared BFT with individual supportive psychotherapy. At nine months and two years follow up, the rate of relapse was significantly lower in the BFT

group and the proportion of patients with remission of positive symptoms was significantly higher for the BFT intervention.

Pharaoh and colleagues (2007) undertook a meta-analysis of 45 studies (a total of 4124 participants) which evaluated the effectiveness of family interventions for schizophrenia compared with standard care. This meta-analysis excluded 75 studies, of which 42 per cent were due to inadequate data reporting. Other reasons for exclusions were related to trials not being randomised, trials including hospitalised patients and trials not providing comparisons to standard care (Pharaoh *et al.*, 2007). This meta-analysis concluded that family interventions were more effective than standard care alone in terms of reduced relapse rates at 12, 18 and 24 months and were equal to standard care at three year follow-up.

A previous meta-analysis (Pharaoh *et al.*, 1999) containing 13 studies suggested that family interventions were moderately effective in terms of lowering relapse and re-hospitalization rates. However, Pharaoh and colleagues (2007) concluded that they were 'not confident' of the effects of family intervention, but that "clinicians may feel that family intervention is worth the time and effort, if high quality family services are available" (p16). The National Institute of Clinical Excellence guidelines for the management of schizophrenia (NICE, 2002) currently recommends that family interventions be offered to all families.

Family benefits

Falloon's review of 25 studies comparing psychoeducational family interventions for schizophrenic disorders identified six studies evaluating family benefits in terms of reducing stress associated with caring for the patient (Falloon, 2003). Five of the six studies reviewed by Falloon (2003) for family benefits showed significant reductions in the stress rating scale outcome for the family intervention group compared with the standard treatment group (Falloon *et al.*, 1985; Veltro *et al.*, 1996; Xiang *et al.*, 1994; Zhang & Jan, 1993; Zhang *et al.*, 1998).

Pharaoh and colleagues (2007) reviewed studies investigating family burden, reporting varied evidence of the effectiveness of family interventions. Of the five studies reviewed, two showed significant reductions in family burden (Chien *et al.*, 2004; Xiang *et al.*, 1994) and three showed no clear reduction of the family burden in the family intervention group (Block *et al.*, 1995; Falloon *et al.*, 1981; Szumukler *et al.*, 2003).

Family interventions compared to individual therapy

Pitschel-Walz and colleagues (2001) undertook a meta-analysis of 25 studies evaluating family interventions for schizophrenia. Six of the reviewed studies compared family therapy with individual therapy. At 12 months and two year follow up, relapse rates showed no significant differences between the two groups, however the relapse rates for the family intervention group were found to be lower at two year follow up (Falloon *et al.*, 1985; Hogarty *et al.*, 1991; Hogarty *et al.*, 1997; Kelly & Scott, 1990; Ro-Trock *et al.*, 1977; Telles *et al.*, 1995).

Family interventions for early onset of psychosis

There has been relatively little research on the effectiveness of family interventions for recent onset psychosis. Goldstein and colleagues (1978) suggested that for individuals with first episode psychosis, briefer family intervention approaches focusing on psychoeducation and crisis management could be of benefit. Linszen and colleagues (1996) study which included a significant proportion of participants with first episode psychosis compared BFT with standard treatment and indicated no differences in relapse rates between the two groups. They suggested that the BFT intervention for some families appeared to have the adverse effect of increasing levels of distress (Linszen *et al.*, 1996). More recently a study by Grawe and colleagues (2004) again found no differences in relapse and hospitalisation rates for family interventions for recent onset psychosis but indicated a reduction in negative symptoms.

Economic benefits

Economic benefits can be understood as a secondary outcome of improvement in clinical and family functioning in terms of reduction in medical and social care costs (Falloon, 2003).

Pharaoh and colleagues (2007) identified three studies that included some economic analysis of family interventions. Firstly, Falloon and colleagues' (1981) study measuring direct and indirect costs of medical and community care for family interventions compared to standard treatment. They reported that at one year post intervention, the family intervention group combined direct and indirect costs were approximately 20 per cent less

than those of the control group. Secondly, Tarrier and colleagues' (1991) study measuring direct costs only and showed a decrease of 27 per cent in the mean cost per patient in family intervention groups. Thirdly, Xiong and colleagues' (1994) study in China reported a 58 per cent saving of the per capita income in China, although direct comparisons are limited due to the different medical and welfare systems.

Further research is needed in this area but the little available evidence suggests positive implications for costs of family interventions; interpreting these finding conservatively, they suggest that family interventions are at worst not more costly to services (Pharaoh *et al.*, 2007).

Family interventions in clinical settings

A criticism of family intervention studies is that the approaches used in trials may not be fully replicable in clinical settings (Falloon, 2003). If interventions are adapted or simplified for clinical settings, the applicability of the current evidence on clinical trials may be doubtful.

However, Falloon (2003) reviewed several studies that were successful in replicating the effectiveness of family interventions found in the controlled trials, showing family interventions to be equally effective in clinical settings (Barrowclough *et al.*, 1999; Berglund, 1996; Bertrando *et al.*, 1998; Brooker *et al.*, 1994; Brooker *et al.*, 1992; Herz *et al.*, 2000; Kottgen *et al.*, 1984; Levene *et al.*, 1998; Rund *et al.*, 1994; Xiang *et al.*, 1994).

1.4.5 Evidence base for systemic family interventions

Systemic family therapy has been widely studied in its application to a variety of disorders and difficulties. However, unlike the significant research interest in the effectiveness of psychoeducational family interventions for psychosis, there have been relatively few controlled studies evaluating the effectiveness of systemic family therapies for schizophrenia.

Systemic family therapy shares key common features with psychoeducational family interventions, in that they both place importance on external factors such as family interactions and relationships on the impact on illness. However, they differ in several ways (Burbach, 1996). The primary focus of psychoeducational family intervention is the relationships within the family, while systemic family therapy also focuses on the impact of wider social relationships on psychological difficulties and takes into account the role played by various factors in an individual's social context. Systemic therapy explores the belief systems, roles and interactions within a family against the background of their social context, whereas BFT is focused on behavioural changes that result from improved communication, problem solving and stress reduction.

The literature has tended to focus more on the theory and practice of systemic family approaches than on evaluating its effectiveness. This is partly due to difficulties related to measuring outcomes or change (Bennun, 1986). However, several studies have sought to evaluate treatment in terms of traditional outcome measures of symptom reduction and relapse.

Bennun (1986) compared systemic family therapy using the Milan approach (Palazzoli *et al.*, 1978) to problem solving family therapy for patients with various psychiatric disorders such as depression, phobias, eating disorders and alcoholism. The Milan approach places emphasis on a particular style of circular and reflective questioning focusing on each family member's beliefs about relationships (Palazzoli *et al.*, 1978). Results suggested that both interventions were equally effective in producing symptom changes but that the problem solving approach proved less successful in effecting second order changes understood as wider system change or systemic change within the family. .

De Giacomo and colleagues (1997) compared systemic family intervention (an interactive approach based on a specific paradoxically structured model, namely the elementary pragmatic model (De Giacomo, 1993; De Giacomo *et al.*, 1996; 1990)) combined with drug treatment with standard pharmacological treatment alone. They emphasised the differences in the systemic model used compared to psychoeducational family intervention. The systemic group received no specific educational or social skills training and described their model as 'radically paradoxical'. At one year follow-up both treatment groups showed clinical improvements and the systemic family therapy group showed significantly reduced rates of relapse compared to the standard treatment group.

De Giacomo and colleagues (1997) concluded that results suggested that systemic family intervention could be used as an effective stand alone therapy model as well as a model integrated with psychoeducational family therapy.

Bressi and colleagues (2008) provided the first randomized study comparing systemic family therapy using the Milan school approach with routine psychiatric treatment for schizophrenia. Bressi and colleagues (2008) results suggested that the systemic family intervention group showed reduced relapse rates compared to the routine psychiatric treatment group, and also significantly better compliance with medication. At two year follow-up no differences between the groups were found. However, results at one year follow-up showed significant similarities to the results of the prominent studies evaluating the effectiveness of psychoeducational family therapy (e.g. Falloon *et al.*, 1982; Hogarty *et al.*, 1986; Leff *et al.*, 1982; Tarrier *et al.*, 1989).

1.5 BEHAVIOURAL FAMILY THERAPY FOR PSYCHOSIS

The present study aims to investigate the manualised psychoeducational family intervention 'Behavioural Family Therapy' (BFT) developed by Ian Falloon and colleagues (Falloon *et al.*, 2004; 2002; 1996; 1984). There are other manualised approaches available (e.g. Anderson *et al.*, 1986), but BFT is the main psychoeducational family approach adopted by clinicians in the local National Health Service (NHS) where this study was conducted and was therefore chosen as its focus. The following section describes the principles and techniques used in BFT.

1.5.1 Structure of BFT

BFT is a predominantly behavioural therapy aimed at enhancing problem solving, communication and goal achievement in a family (Falloon *et al.*, 1984; 2004). Although it

is a structured therapy approach using predefined sessions, flexibility is emphasised, with the family worker¹ aiming to be responsive to the needs of individuals within each family (Falloon *et al.*, 2004).

The general structure set out in the BFT manual (Falloon *et al.*, 2004) is described below:

- Assessment of individual family members' communication and problem solving styles
- Formulation of family resources, difficulties and goals
- Introduction and establishment of regular 'structured family meetings' without the family worker
- Psychoeducation on psychosis
- Communication skills training in active listening, expressing positive and unpleasant feelings and making positive requests, and problem solving training
- Evaluation and feedback

Falloon and colleagues' (2004) BFT manual suggests an average of ten to twelve sessions of BFT with follow-up contact by the family worker for up to a year after completion. The manual places emphasis on engagement of the family at the start of therapy, with the aim of establishing a collaborative relationship with family being viewed as the "best natural resource for helping an individual cope with life stresses" (Falloon *et al.*, 2004, p9).

¹ Trained BFT clinicians are commonly referred to as 'family workers'. The same terminology was used within this study.

A positive, non-blaming attitude on the part of the family worker is promoted within the approach, in order to create this working collaborative relationship. At the start of the therapy process, emphasis is also placed psychoeducation about the aetiology, prognosis and symptomatology of psychosis. Whilst this is led by the family worker, the approach acknowledges the patient as the expert on his or her psychotic experiences.

BFT is conducted with the individual with psychosis and his or her family members. The manual advocates the use of initial individual sessions with each family member to identify individual goals before group sessions begin and the opportunity for further individual sessions to discuss any concerns, provided this is done with the agreement of other family members.

BFT focuses on identifying unhelpful patterns of behaviour within the family and introducing strategies to improve family functioning. The therapeutic process is active, with family members encouraged to identify problematic issues and areas of stress. When families are new to the process and are developing skills, more 'straightforward' difficulties are selected for discussion, for example household tasks, before progressing to more complex issues such as management of disruptive behaviour (Falloon *et al.*, 2004).

The approach acknowledges that the family environment can become negative and focuses on promoting positive communication and behavioral patterns. These include identification of positive aspects already in family relationships and introducing constructive communication strategies.

Falloon and colleagues' (2004) manual also acknowledges the difficulty in expressed negative feelings such as anger, sadness and disappointment. The intervention encourages the expression of existing unpleasant feelings in construction ways and promotes behaviours aimed at reducing negative feelings and stress within the family. All the skills acquired in BFT are practiced in the sessions using modelling, role-play and homework.

1.5.2 Current insights into families' experiences of BFT

Campbell (2004) provided the only study examining families' subjective perceptions of receiving BFT. This was a phenomenological enquiry into the lived experiences of ten families (using group interviews), with one family member having a diagnosis of schizophrenia, bipolar disorder or severe depression. He reported that overall families were 'very satisfied' with the intervention. The main themes emerging from this study were engagement with BFT, therapists' qualities, the practice of BFT, perceived gains attributable to BFT and empowerment of the patient and the family.

Families described engagement as a process of negotiation that was perceived as a 'real choice'. Many carers expressed the view that BFT provided the first forum they had encountered in which they felt professionals were taking their views into consideration. In terms of family workers' qualities, Campbell reported that families overwhelmingly viewed their family worker as professional, informed, friendly and understanding. Families viewed the various components of BFT very favorably, including the communication skills training and psychoeducation.

Campbell (2004) reported that the most important gains perceived by families were the contact received from the family worker and the perception of carers that they had a 'voice' in the treatment of their relative. These interesting findings suggest that from the family perspective the therapeutic atmosphere of BFT may be more valued than the opportunities for skills acquisition.

1.6 RATIONALE FOR THE PRESENT STUDY

This thesis aimed to explore the processes involved in BFT for psychosis using a constructivist grounded theory methodology. The author chose this area of study and this design for a number of reasons. The following section gives a rationale for the study area and recognition that it was conducted as a requirement of a clinical psychology doctoral training. In keeping with the qualitative tradition, a statement of the researcher's personal interest and intent is included in the methodology section (section 2.4.2).

In the author's final year of training, she worked in a severe and enduring mental illness clinical psychology service. Over the first few months of my placement I began to wonder why none of the patients referred to me had received or been offered family intervention, despite the fact that most were living with their families or considered members of their families to be their main carers. I found that a common topic of discussion within my individual therapy sessions was family relationships, both problematic and supportive, since families formed my patients' main social network.

In addition to these observations I had discussions with my clinical supervisor, a trained BFT clinician and BFT trainer, on the effectiveness of family interventions as shown in the literature. His personal clinical experience was that families appeared to benefit greatly from this intervention, but while changes in family functioning were identifiable, the processes underlying these benefits appeared less clear. It is these processes that this thesis attempts to explore.

As already noted, some researchers have suggested that the benefits of family interventions are at best moderate (e.g. Pharaoh *et al.*, 1999) but propose that investigating the views of families may provide further understanding into outcomes for those families.

1.7 AIMS OF THE STUDY

The large body of research in this area has been concerned with the effectiveness of BFT predominately in terms of reducing the rate of relapse. This present study aims to gain a deeper understanding of the processes involved in BFT.

Broad research question

What is the lived experience of individuals within families that have received BFT?

Supplementary questions

- Do families perceive that there has been a change as a result of BFT?

- What are the processes involved in change?
- What are the effective elements of BFT as perceived by participants?

2. METHODOLOGY

2.1 DESIGN

This study employed a qualitative methodology for several reasons. Firstly, qualitative methodology allows for deeper exploration of individual experiences. Secondly, there is a lack of qualitative research in this area compared to quantitative research and correspondingly a need for more qualitative research. Thirdly, this study builds on Campbell's (2004) qualitative research into families experiences of BFT and so a broadly similar investigative approach was considered appropriate.

2.1.1 Qualitative methods

The two prominent qualitative methods are grounded theory (Charmaz, 2003; Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1990) and interpretative phenomenological analysis (IPA) (Smith, 1995). These approaches are perhaps most easily distinguished by differences in the area of interpretation: IPA begins the processes of analysis and interpretation simultaneously, whereas grounded theory requires an initial, more open 'explorative' analysis before the work of interpretation can begin.

The chosen methodology for the current study is constructivist grounded theory. The reasons for this choice, the background of the theory and its procedural implementation are described below.

2.1.2 Grounded theory

Grounded theory was first developed by Glaser and Strauss (1967). They stipulated that unlike quantitative approaches where the researcher uses hypotheses to test a theory, the researcher's is required to collect and analyse data simultaneously without preconceptions, thereby allowing analytic codes and categories to emerge gradually from the data. Glaser and Strauss (1967) considered the researcher to be an objective observer and through data collection and analysis a generalisable 'truth' could be discovered. Categories of understanding the area under investigation are developed through the 'constant comparative' method (Glaser & Strauss, 1967) by which all data that has been collected and analysed is continuously cross-referenced with new data coming in.

2.1.3 Constructivist grounded theory

Constructivist grounded theory (Charmaz, 2003) attempts to retain the essential character of grounded theory, such as the constant comparative method and lack of *a priori* hypotheses, while rejecting its positivist assumptions. Charmaz (2003; 2006) proposed several departures from (Glaser & Strauss, 1967) original grounded theory principles.

She rejected the notion of the objective observer and the notion that theories can be discovered from the data. Rather, she viewed the researcher as part of what was being investigated and therefore integral to data collection and analysis. Thereby, the construction of grounded theories are seen as an "interactive portrayal of the studied world, not an exact picture of it" (Charmaz, 2006, p10). Within this both the researcher and participant were required to collaborate to 'construct' a narrative of the participant's experiences (Charmaz,

2003). Charmaz (2003; 2006) also emphasised the importance of the local context of the research and the social, professional and socio-economic context of participants and researcher.

2.2 PROCEDURE

2.2.1 Sampling

As the researcher was interested in understanding the experiences of a specific group of people, purposive sampling techniques were employed whereby participants were selected according to the criteria of relevance to the research question. The group under investigation for the present study consisted of individuals within families who had received BFT for psychosis.

2.2.2 Inclusion and exclusion criteria

Inclusion Criteria:

- At least one member (key person²) of the family having a primary diagnosis of psychosis³
- All participants having completed a full course of BFT within the last two years
- At least two members of each family unit agreeing to participate in the study
- All participants being over the age of 14
- All participants being able to give informed consent

² Within BFT the individual with psychosis is commonly referred to as the 'key person'. In line with this, these participants will be referred to as 'key person(s)' within this study.

³ The generic term 'psychosis' used throughout this study includes all psychotic disorders.

Exclusion Criteria:

- Key person participants being in an acute phase of psychotic illness
- Participants being unable to give informed consent

2.2.3 Recruitment

Family workers in the selected NHS trust⁴ were informed of the research via group email and through presentations in BFT supervision groups by the researcher. Family workers were invited to propose families for potential participation (cf. appendix I: family referral form). After this initial stage of referrals, family workers were contacted via email and telephone to prompt further referrals. All referrals were discussed with the family worker to ensure that inclusion criteria were met.

All suitable families referred were initially contacted via telephone by their family worker to introduce the study and ask permission for written information to be sent. All families agreed to be contacted by the researcher who then sent information sheets (cf. appendix II) with a covering letter (cf. appendix III) inviting each family member to participate. This was followed a week later with a telephone call by the researcher, giving families an opportunity to ask questions and gain more information. Several telephone conversations were necessary to speak individually with all family members. Individuals were then asked if they wished to participate and interview times were arranged.

⁴ Due to the confidentiality limits advised by the University of Edinburgh, all identifiable information regarding the locality of this study has been removed.

Participants were given the choice of conducting interviews in their homes or in their local health centre. All but one participant chose their home as the interview setting. This seemed fitting as BFT interventions were also conducted in the home.

2.2.4 Participants

Eight families were initially referred to the study, of which two families did not meet the full criteria and one family chose not to participate after receiving the information sheet. In total, 16 participants (from five families) were recruited to the study. Out of this, 15 participants completed the study and one participant (a key person) decided to withdraw before the interview stage.

2.2.5 Data collection

Individual interviews were chosen as the method of data collection, in order to allow exploration of each family member's unique experience. This differed from Campbell's (2004) methodology, which used family group interviews. Although group interviews with each family is a valid form of data collection, it produces narratives based within the context of family group dynamics and would assume that each individual was comfortable sharing potentially conflicting opinions or personal reflections with his or her family. The present study aimed to investigate the experience of having received BFT from a different perspective using individual interviews.

A semi-structured interview format was used to explore the participants' experiences of having received BFT, their perceptions of any changes as a result of BFT and their

perceptions of the effective elements of BFT. The questions were based on a simple interview schedule but the semi-structured format enabled flexible exploration of individuals' experiences by allowing follow-up questions in response to their answers (cf. appendix IV: interview questions schedule; appendix V: transcript notations).

The researcher encouraged participants to take the lead in the conversation by explicitly asking them to do so at the start of interviews. The questions were open-ended, so as to reduce assumptions about participants' responses. This approach is in line with Glaser (1992), who advocates a 'generalist' method of data collection and suggests that more structured data collection can result in the validation of a preconceived theory, as opposed to the generation of an inductive process.

A preliminary analysis of tentative or emerging themes was carried out following the first three interviews. These emerging themes were then used to inform the formulation of subsequent interview questions. Through this inductive process, interview questions evolved and became more specific, incorporating emerging themes as the interviews progressed. This pattern of interview-analysis-question generation was repeated until all 15 participants had been interviewed.

Constructivist grounded theory acknowledges that the researcher always holds certain views about the research area. While the researcher should aim towards neutrality at each stage of the inductive process, an attempt should also be made to make these views explicit throughout. To avoid subconsciously steering the interviews, the researcher retained an

awareness of her own *a priori* assumptions about possible topics of discussion and themes, which are presented in table 1. A reflective diary was also kept throughout the research process, as discussed below in section 2.2.6.

Table 1: Researcher's pre-existing views about possible themes and topics at the start of the interview process

Possible Topics	Possible Themes
treatments	relationships
psychosis/mental health	emotions
family	communication
clinicians	stigma
enthusiasm/avoidance of topic	conflict

2.2.6 Reflective diary

Throughout the research process, the researcher kept a reflective diary. This provided an opportunity to draw together ideas generated from the interviews. Another important function of the reflective diary was to promote awareness of the researcher's own preconceptions and possible influences on the data analysis. A discussion of points of interest arising from the reflective diary is presented in the discussion (reflective analysis, section 4.3).

2.2.7 Analysis

In qualitative research, analysis is integral to the methodology as it informs subsequent data collection. Within grounded theory methodology, 'coding' is used as the basis of analysis.

The analysis followed three main coding stages in accordance with grounded theory procedures: firstly, 'initial coding'; and 'focused coding' (Charmaz, 2006); and finally, 'axial coding' (Strauss & Corbin, 1990; 1999).

It is important to note that the three stages of coding are not mutually exclusive. Throughout the research process the researcher moved between the different stages to allow generation of the final content and structure of core categories of the experience of individuals who have received BFT. According to constructivist grounded theory, categories are developed cumulatively from the researcher's analysis of each participant's narrative. The narratives of subsequent participants determine the importance or strength of each theme and its development into a category.

Although the themes that formed core categories could be identified early on in analysis, constructivist grounded theory demanded that these themes should be included in the interview schedule of subsequent interviews. In this way, it was possible to assess which themes were consistent across families and individuals and which themes were particular to one individual or one family. A description of each stage of analysis is given below.

At the start of the study, the first interviews represented the beginning of the process of understanding the experience of BFT and there were no pre-existing themes. Digital audio recordings of interviews were transferred onto computer and then transcribed verbatim by the researcher. Transcripts were then coded using the qualitative computer software NVivo

2 (QRS International Pty. Ltd, 2002), a package designed to facilitate qualitative analysis by aiding the organisation of large amounts of data.

Coding stage one: initial coding

A method of explorative coding or ‘initial coding’ (Charmaz, 2006) was used as the first stage of analysis. Initial coding is a means of giving a descriptive label or name to segments of narrative to summarise their possible meanings. This was done line-by-line or sentence-by-sentence for each transcript (cf. appendix VI: extract of transcript with initial coding; appendix V: transcript notations). In NVivo, this process involved highlighting each line of text or sentence and giving it a descriptive label. This label was then saved as an initial code (or, using NVivo terminology, a ‘free node’).

Initial coding enabled the transcripts to be analysed by identifying descriptions of actions, events, thoughts and feelings expressed by the participants (Charmaz, 2006). This early analysis immersed the researcher in participants’ narratives and increased her familiarity with the transcripts to promote staying open to the possibility of different theoretical directions. Initial coding was conducted on all transcripts.

Coding stage two: focused coding

The second stage of analysis was ‘focused coding’ which is more “directive, selective and conceptual” (Charmaz, 2006, p57) than line-by-line descriptive initial coding. Transcripts were re-read (and at times whole sections listened to again) taking into account the initial codes (free nodes). The researcher then wrote ‘memos’ which were notes about points of

interest, questions arising from the initial codes and possible connections and relationships between them, thus moving the analysis in a more interpretative direction. From these memos, the most salient initial codes were identified and selected to become focused codes, representing a more analytic understanding of the initial codes. These focused codes were then used to “synthesise and begin to explain larger amounts of data” (Charmaz, 2006, p57).

Charmaz (2006) emphasised that coding is an ‘emergent process’ where initial codes are compared to each other, allowing the development of focused codes. Larger sections of narratives were then again compared to the emerging focused codes to help refine them. This process allowed for similar initial codes across participants to be examined and grouped together under a wider, more analytic focused code. For example, the initial codes ‘talking more about problems’, ‘opening up problems’ and ‘communication is key’ were grouped together under a focused code ‘communication style’. Each focused code generated through this analysis represented an emerging theme of the experience of BFT.

In NVivo, coding is based on a hierarchy which builds from the bottom up, adjusting the labelling of each level of coding as data is grouped together. Using NVivo terminology, focused codes were generated as ‘tree nodes’. Similar or related free nodes (initial codes) were grouped together under each tree node, thus developing a tree node structure (or focused code structure) to house related initial codes. Using the above example, a tree node labelled ‘communication style’ was generated and the corresponding free nodes ‘talking more about problems’, ‘opening up problems’ and ‘communication is key’ were grouped within it.

As described in the data collection section above (section 2.2.6), emerging themes were used to shape later analysis. Emerging themes generated in early interviews were used to develop the interview questions introduced into subsequent interviews (cf. appendix IV). In this way, narratives of subsequent participants could provide richer descriptions and possible variations within the emerging themes.

As interviews continued, newly generated initial codes that related to previously identified themes were organised into the existing focused code structure. For the initial codes that added new understanding of the experience of BFT, further focused codes were generated and these initial codes were organised within it. This process continued until no new emerging themes were generated from the analysis: this is understood in qualitative research as reaching the point of ‘saturation’.

As focused coding and memo writing continued, emerging themes were further analysed to identify tentative relationships, similarities and differences across participants’ narratives. From this, the most significant focused codes interpreted by the researcher were developed into wider, more analytic subcategories (and finally core categories described in the final stage of coding ‘axial coding’ below) of the experience of having received BFT. Through the constant comparison method (Glaser & Strauss, 1967), related themes (focused codes) were then organised under subcategories and finally under core categories, thereby expanding the focused code structure.

In NVivo, themes were organised by assessment of related existing tree nodes (emerging themes) under subcategory labels generated by the researcher. Using NVivo terminology, these new labels were generated as 'parent' tree nodes. NVivo software then automatically changed the existing tree nodes (themes) into 'sibling nodes' (offshoots of the parent tree node), which in turn housed related free nodes (initial codes). Continuing with the previous example, the tree node (theme) 'communication style' was grouped with other related tree nodes (themes), for example 'active listening' and 'accepting criticism' under the new parent tree node (subcategory) 'problem solving'. NVivo then automatically changed the existing tree nodes (themes) 'communication style', 'active listening' and 'accepting criticism' into sibling nodes which housing groups of related free nodes (initial codes).

Coding stage three: axial coding

'Axial coding' was used in this study as the final stage in the coding process. Strauss and Corbin (1990; 1998) identify 'axial coding' as a strategy to relate core categories to subcategories and identify the properties and dimensions of each category (Charmaz, 2006). Initial coding resulted in participants' narratives being separated into small sections of meaning, while axial coding is a method of weaving separate codes back together to create a coherent whole (Strauss & Corbin, 1998).

Data reduction continued with related subcategories being organised together under emerging core category labels; for example, the core category 'conflict and problem management'. In NVivo, this was achieved by generating a new parent tree node 'conflict and problem management' which then parented the existing tree node structure. The

existing tree nodes (subcategories) were automatically changed to sibling nodes and existing sibling node (themes) were automatically changed to child nodes.

Axial coding helped to further interpret, refine and organise large amounts of data in the initial and focused codes, thereby enriching the researcher's interpretation of the participants' experience of having received BFT. Charmaz (2006) suggests that axial coding aids the development of an emerging core category, while allowing a flexible approach to refine the final categorisation during the end stages of analysis. A large part of this final stage of analysis was done by hand. Paper labels of themes and subcategories were used to experiment with different structures and potential groupings.

Initial and focused coding "shapes the analytic frame from which you build the analysis" (Charmaz, 2006, p. 46). Taken together, both levels of analysis facilitate the constant comparative method (Glaser & Strauss, 1967), whereby every initial code is compared to the others as well as to emerging themes and categories and finally to the hypothesised theory of understanding the phenomena under investigation. This constant comparison method ensures that any theory development is grounded in the data. In this way, constructivist grounded theory involves a clear evolution of themes into categories which can be traced directly back to individual narratives. Focused coding and axial coding aid the development of a theory, since emerging themes may be compared to the data for correctness and appropriateness of fit (cf. appendix VII provides examples of the development of analysis at the beginning, middle and end stages of analysis).

2.2.8 Saturation

Data collection was stopped after the analysis of the 15 interviews. Although complete saturation can never be achieved due to the inherent uniqueness of an individual experience, after 15 interviews no further new themes were generated from the narratives.

2.2.9 Structure of core categories

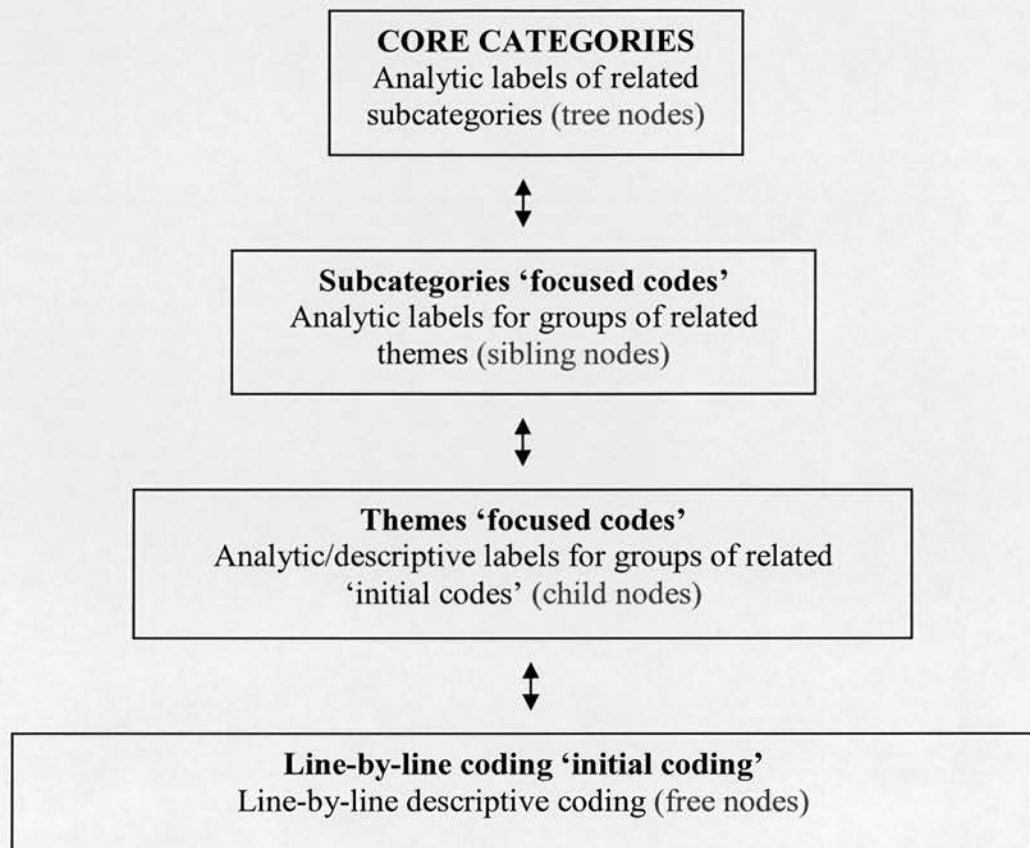
From a top down perspective core categories (tree nodes) are composed of a number of related subcategories (sibling nodes). Subcategories are further divided into related themes (child nodes) taken directly from the participants' narratives (initial coding) (see figure 1). Based on the categories developed from the themes, the decision was made to group categories across all participants, whether key person or other family member, as well as across the families. This organisation of categories was chosen as it appeared to fit the narratives of all participants most closely, as the experiences of BFT were for the most part similar across participants, across families and also between key persons and other family members. Differences between participants have been noted wherever they occurred.

2.2.10 Theory development

In this final stage of analysis, core categories, sub categories and themes developed through coding were analysed with reference to the existing literature on the topic area. This allowed for core categories of participants' experience of having received BFT to be placed within the context of wider understanding from research on family environments and

family focused interventions for psychosis. By reviewing the relevant literature, theoretical links with, similarities to and differences from the current knowledge in this area could be interpreted to form hypotheses about core categories and integrate them into a theory or model of the mechanism involved in BFT.

Figure 1: Structure of core categories (NVivo 2 terminology)



2.3 ETHICAL ISSUES

Ethical approval was granted by the Local Research Ethical Committee (cf. appendix VIII) before commencement of the study. Approval was also granted by the local NHS Research

and Development Department (cf. appendix IX). The main ethical considerations for this study are described below.

2.3.1 Informed consent

All participants received an information sheet describing the research and were given the opportunity to ask questions and discuss issues directly with the researcher and their family worker. All participants were asked to complete and sign a consent form (cf. appendix X) before participation in the study.

2.3.2 Free to withdraw participation

Participants were made aware by means of the information sheet and also verbally by the researcher before interviews that they were free to withdraw their participation at any stage of the study without needing to give a reason. They were informed that a decision to withdraw would not affect any present or future NHS treatment.

It was also felt appropriate to allow participants ample time to withdraw from the study if they so wished, so a two week period was arranged between the participants' agreement to participate and the date of the first interview.

2.3.3 Preventing harm

This study applied several strategies to limit the potential harm to participants. Participants were informed of the limits of clinical confidentiality. They were also informed that they did not have to share any information which they perceived to be sensitive or which made

them feel uncomfortable. If participants felt distressed at any stage during interviews they were given the opportunity to take a break, stop and reschedule or withdraw from the study. None of these actions were in fact required in any of the interviews. At the end of the interviews, the researcher allowed time for participants to discuss how the interview made them feel and whether there were any potential concerns about their involvement in the study. They were also informed of the opportunity to discuss any distressing feelings resulting from the interview with a clinical psychologist independent of the researcher. Again, this option was not taken up by any of the participants.

2.3.4 Benefits for participants

It was hoped that the research would be of interest to participants as it was an opportunity to have their views heard, with the wider benefit that their experiences might make a contribution towards a deeper understanding of BFT.

2.4 RESEARCH CONTEXT

In qualitative research, it is important to have an understanding of the context in which it is conducted so as to gain more insight into the research and to limit potential biases (McCotter, 2001; Peshkin *et al.*, 1998). In this light, information is given below on the NHS organisation from which participants were recruited and on the researcher's background.

2.4.1 NHS organisation

This research was set within an NHS trust covering a large urban area as well as rural areas, with a wide overall range of economic diversity. BFT family workers came from nursing, occupational therapy and clinical psychology professional backgrounds and received regular BFT group supervision. All underwent a standardised BFT training process developed by The Meridian Family Intervention Group⁵.

2.4.2 Information about the researcher

It is important that the reader be aware of factors that may affect the objectivity of the researcher. I am a 28-year-old British female raised in London. My family is from a white Eastern European background and middle class socio-economic status. I consider my family to be very close, loving and supportive. I would guess that if we were ever formally assessed for EE we would be rated as high on EOI, warmth and criticism, and low on hostility. Contrary to the negative connotations attached to EE literature, I do not consider my family dysfunctional in any way but rather view these attributes as a 'normal' style of relationship interactions.

I moved to Scotland to undergo training in clinical psychology and was in my final year at the time of writing this thesis. To date, most of my clinical experience has been within a cognitive behavioural framework and most of my research activity has used quantitative

⁵ The Meridian Family Intervention Group (West Midlands) was set up in 1997 with the aim to promote the implementation of evidence-based practice in clinical services. It developed a cascading BFT training process whereby BFT family workers are trained as BFT trainers. These trainers then provide in-service training in their locality.

enquiry. Whilst I conducted this research, the clinical component of my training was within a severe and enduring clinical psychology service. I have not been trained as a BFT family worker.

2.5 ENSURING QUALITY IN QUALITATIVE RESEARCH

As with quantitative research, qualitative research aims to produce valid findings. The concept of 'trustworthiness' (Lincoln & Guba, 1985; Schwandt, 1997), incorporating four elements: credibility, transferability, dependability and confirmability, is used to indicate the level of rigor in qualitative approaches.

2.5.1. Credibility

Credibility is understood as the extent to which research findings (categories and themes) correctly represent the experience of participants. To ensure credibility 'member checks' and 'triangulation' of techniques (Janesick, 2002) were used in this study. Member checks were used to test the credibility of emerging themes by introducing them for discussion in later interviews. In this way, the participants were able to judge the extent or relevance of each theme.

Triangulation (Janesick, 2002) can involve multiple data sources (for example, individual interviews, focus groups and direct observation of the area under investigation), multiple investigators or multiple methods techniques. Triangulation is aimed at limiting the

potential to misinterpret the data means of avoiding interpreting themes too soon or misinterpreting data and therefore misdirecting research questions and later analysis.

Several triangulation techniques were used in this study. Participants were recruited from multiple sources (referred by different family workers) and interviews were conducted at different times in relation to the conclusion of BFT. BFT had been conducted with families at different stages of the key person's psychosis (spanning from participation in BFT several month after the first psychotic episode to participation in BFT for over 15 years from the time of diagnosis). The BFT family workers came from different professional backgrounds, had different levels of BFT experience (from working with one to more than five families) and were under supervision from different BFT supervisors. Although this study had only one investigator, research transcripts, coding and emerging themes were reviewed by the researcher's clinical supervisor at several stages of the analysis process.

2.5.2 Transferability

Transferability is understood as the extent to which research findings can be transferred or applied to different situations and settings. Again, several transferability strategies were used. Firstly, the researcher's personal and professional background along with participants' social family context was detailed, thus allow the reader to factor in the cultural and economic context.

Secondly, purposive sampling was employed. Families were recruited according to the researcher's interest in understanding experiences of individuals who had received BFT. The third strategy to enhance transferability consisted of the use of 'thick descriptions' (Lincoln & Guba, 1985) in the results section of the study. Thick descriptions were used in the form of direct quotations from participants' narratives used to illustrate and represent larger sections of data. They aimed to provide transparency of the results showing the relationship between the researcher's interpretation of analysis and participants narratives.

2.5.3 Dependency

Dependency refers to the level of reliability of research findings. To promote dependency within the study, an audit trail was developed through the methods of memo writing and reflective diary. These methods produced a record of the researcher's interaction and analysis of the data throughout the research process. Erlandson (1993) suggests that reliability can be assessed by the extent to which replication of the study with similar participants in terms of their social context, would produce the same or similar findings.

2.5.4 Confirmability

Finally, confirmability aims to demonstrate that research findings have not been overly steered by researcher bias. Constructivist grounded theory (Charmaz, 2006; 2003) acknowledged that researcher cannot remain completely objective and emphasizes researchers role in interacting with participants and with analysis. The current study paid particular attention to potential researcher biases throughout the research process, primarily by means of the research diary to record preconceptions about possible topics before the

start of data collection (presented in table 1) and throughout data collection, analysis and model generation stages.

The researcher also gained support from peers who were conducting research using qualitative methodology. Regular group meetings were organized and a group email was set up for the purpose of peer support and circulation of information.

3. RESULTS

The results section is divided into three subsections. First, a description of the family context of participants is presented. Second, the descriptive results are presented, consisting of a description of core categories generated from data analysis with reference to direct quotes from participants' transcripts. Finally, the inferred results are presented, consisting of an analysis of the descriptive results in relation to the literature base and the presentation of a hypothesised model of the mechanisms involved in BFT.

3.1 FAMILY CONTEXT OF PARTICIPANTS

A summary of each family's makeup and background is provided below. This is aimed at increasing the transparency of findings as well as at assisting in their contextualisation. According to the theory behind BFT, families' experiences of the therapeutic process are informed by their family context and background (cf. appendix XI for a table of demographic information).

Family 1: Three members of this family received BFT and agreed to participate in this study: key person, mother and adult sister. The key person was male, 48 years old and had a longstanding diagnosis of paranoid schizophrenia. He had lived in his family home with his mother since his twenties when he first became ill. They completed BFT two years prior to participation in this study.

Family 2: Three members of this family received BFT and agreed to participate in this study: key person, mother and father. The key person was female and 25 years old. Following her first episode of psychosis, she had returned to live in the family home. BFT was started soon after her discharge from hospital. They completed this family intervention 18 months prior to participation in this study.

Family 3: Three members of this family received BFT and two agreed to participate in this study: key person and partner. The key person was male, 43 years old and had a long-standing diagnosis of paranoid schizophrenia and alcoholism. He lived with his partner and daughter. They completed BFT six months before participating in this study.

Family 4: Four members of this family received BFT and all agreed to participate in this study: key person, mother, father and younger brother. They all lived in the family home. The key person was female, 18 years old and had a diagnosis of psychosis. They received BFT after her second discharge from hospital and completed BFT one month before participating in this study.

Family 5: Six members of this family received BFT, of whom three agreed to participate: mother, father and brother. The key person chose to withdraw from the study and his two younger brothers did not meet the age criteria for participation. The key person was male, 19 years old and had a diagnosis of psychosis. They all lived in the family home. The family received BFT shortly after his first discharge from hospital. They completed BFT two months before participating in this study.

These families received an average of 14 BFT sessions (range 12-16). All key persons were receiving standard psychiatric treatment during their participation in BFT and at the time of interview for this study.

All interviews took place in participants' homes except one interview, for which the participant chose an outpatient setting. All interviews were conducted in private between the participant and the researcher, except in the case of family 3 (key person and partner) because they expressed a preference to remain together whilst being interviewed separately, due to limited space in their home. The implications of this on their interviews will be considered in the discussion (section 4.3.3).

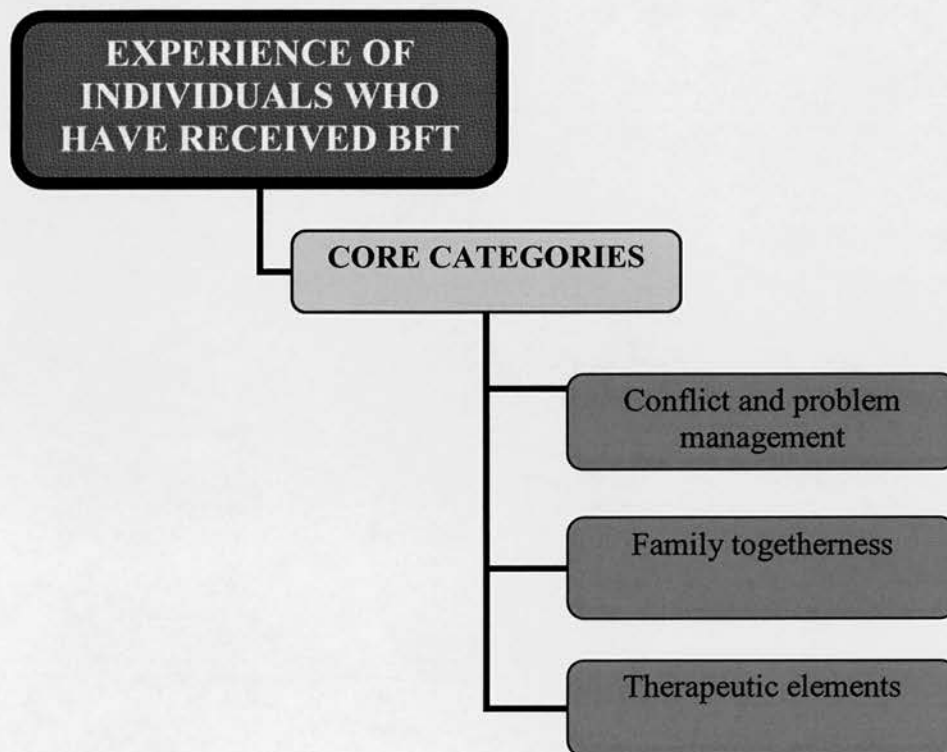
Several differences between these families were evident: key person's age, diagnosis, length of illness and length of time since families completed BFT.

3.2 DESCRIPTIVE RESULTS

3.2.1 Core categories

Three core categories were generated from the analysis of participants' narratives: 'conflict and problem management', 'family togetherness' and 'therapeutic elements' (see figure 2).

Figure 2: core categories generated from the narratives

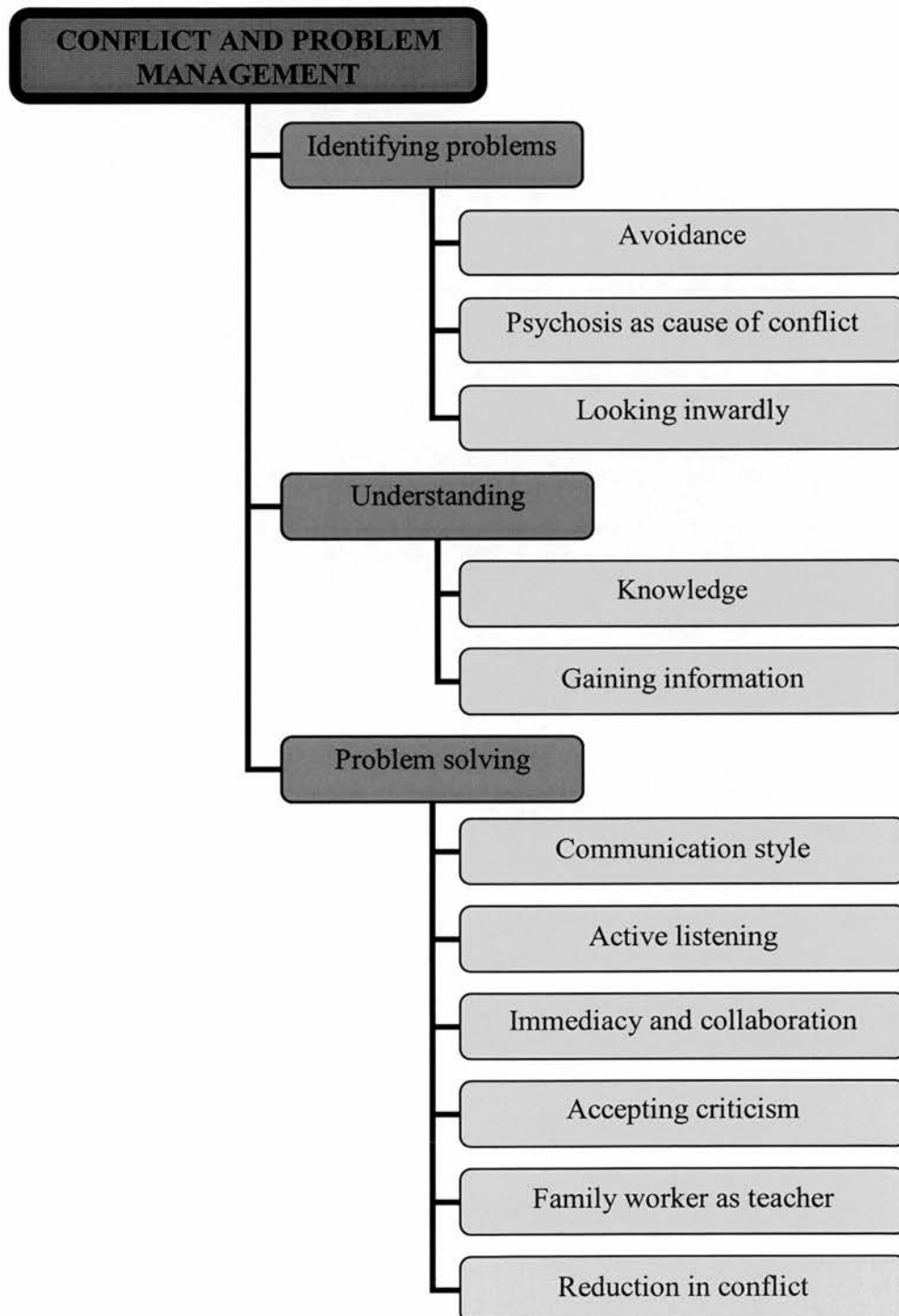


3.2.2 Core category 'conflict and problem management'

The core category 'conflict and problem management' is made up of three subcategories: 'identifying problems', 'understanding' and 'problem solving'. Each subcategory is further

divided into themes (see figure 3). The core category ‘conflict and problem management’ was the most emphasized by participants.

Figure 3: Core category ‘conflict & problem management’



Subcategory 'identifying problems'

The subcategory 'identifying problems' refers to participants' descriptions of the problems and difficulties within the family that were identified in BFT sessions. This subcategory comprises of three themes: 'avoidance', 'psychosis as cause of conflict' and 'looking inwardly'.

Avoidance

The theme 'avoidance' concerns participants' descriptions of their interaction style within the family before BFT. Participants described behavioural patterns and difficulties in expressing feelings to other family members. Avoidance behaviours were identified in BFT sessions through discussions on communication styles and interactions within in the family. Some participants reflected that although they had previously been aware of unhelpful patterns of behaviour before BFT, BFT sessions aided them in directly highlighting these difficulties in an open manner. Alongside this, participants described BFT as helping them to express emotions to family members instead of repressing them as had previously been the case.

It opened things up a bit in the meetings {BFT sessions}, I'm bad for keeping things in because I don't know how [key person] will react and don't want to start an argument. But it would always come out coz it would be building up inside, so it was better to have it out in the meeting {BFT session}, talk about what was bothering me, you know little things the children still do, like not cleaning and [key person] not getting up in the mornings.

Family 4, mother

The avoidance behaviours before BFT appeared to be linked to fear of provoking confrontation. Family member participants expressed that they had previously worried about unsettling the key person and having to deal with potential uncontained behaviour.

Definitely, it {BFT} gave you a good insight into it {the illness} and helped us as a family because we didn't know...we were sort of tiptoeing around each other which... it took away that kind of situation. So we were able to sit down and speak about it in that kind of structured way.

Family 2, mother

When we talked with [family worker] it was easier to say things that we'd probably been avoiding. I never used to want to say that was upsetting me, if something was upsetting me, because I didn't want to get [key person] worked up and upset. But talking about any issues was better than keeping them inside, I thought it was really useful.

Family 1, sister

Psychosis as cause of conflict

When describing what issues were raised in BFT sessions, many participants referred to psychosis as the cause of arguments. They portrayed arguments as directly related to the key person's behaviour as a consequence of illness. The strategies to reduce conflict learned in BFT sessions were seen as helpful for coping.

(key person): I blamed [partner] for a lot of my illness as well. Cos we weren't getting on and I thought she was being ungrateful and all. Oh, it just did, just did my head. It went crazy(...).

(researcher): Right, and was it the family work that had an impact on this?

(key person): Yes, definitely, it made us...you know realise that we shouldn't take each other for granted. We needed to talk more.

Family 3, key person

I think [key person] used to get quite angry within herself. And I found that quite difficult and it was up to me, well not just me, but it was me that she really took it out on. So we needed strategies {developed in BFT} of how to calm the situations down and that did help a lot.

Family 4, mother

Some family member participants described difficulty in identifying whether certain aspects of the key person's behaviour were due to psychosis or character. Although participants identified improvements in avoidance behaviour and dealing with the conflict associated

with psychosis as a result of BFT, for some, confusion remained in terms of separating key person behaviours and illness.

It's very difficult to judge, hard to know, it's a very difficult illness to judge, but basically he's a good person, I mean you can see through him sometimes and he also has the right as a person to have some bad parts. I mean I won't call myself an angel so I don't expect him to be an angel, it's just that these difficult parts, it's very difficult. And even when he's difficult it may not be due to mental illness. But it {BFT session} helped us put it into some kind of perspective, showing the family tools to deal with the things you're not happy with.

Family 5, father

Looking Inwardly

Participants described how they felt able to examine other behavioural and interactional styles (aside from avoidance) in BFT sessions. Behavioural styles varied between participants, for example over-protectiveness, critical or authoritarian behaviour. Participation in BFT sessions not only resulted in more explicit self-reflection, but was also described as leading to changes in some of these behaviours.

(mother): I suppose and again because of my nursing background, I tend to smother a bit and overprotect. And I had to challenge myself about that a lot and say to myself 'I don't know so much', because I'm much more relaxed than I was. And again I think that the family work that we did has enabled me to be a bit more relaxed than I was, as well.

(researcher): Is that something you noticed about yourself before the family therapy?

(mother): I don't, I wasn't internally aware before. I may have been up here {indicates head} but not in here {indicates heart}. You know not, I may have...it may have been tokenism but not real.

Family 1, mother

It {BFT} made you think about how you were acting, you know really think about it instead of just behaving in the usual bad habits that everyone has. Sometimes I can be quite snappy and I don't really realise I'm doing it, I just tell the children to do something in stead of asking properly, but we went through different ways of talking to each other and making positive requires, it set me thinking that I didn't always do things in the best way, so it was an improvement.

Family 5, mother

One key person characterised 'looking inwardly' as a difficult process. This was expressed in terms of discussions within BFT sessions having a negative impact on her mood as she internalised comments made about her behaviour by others in the family. However, 'looking inwardly' helped her to work through negative feelings in a helpful manner.

When I was going through hard times and I had to sit through the meetings {BFT sessions} it made me feel worse a lot of the time and there were occasional times when things were brought up at the meetings {BFT sessions}, my parents and all that, which made me feel upset or they'd say something that I'd never thought about before and it would stick in my mind so I'd think 'why is that?' or 'why do I do that?' and then I'd get annoyed at myself but I've worked through that and it's helped.

Family 4, key person

Subcategory 'Understanding'

The subcategory 'understanding' is divided into two themes: 'knowledge' and 'gaining information'.

Knowledge

Two families chose not to explore directly the impact of psychosis during BFT as they felt that they understood psychosis and felt that discussing it would have a negative impact on the key person and the family. For these participants, BFT was perceived as aimed at dealing with problems within the family environment without focusing on the key person's illness.

[Key person] doesn't like talking about that {illness} very much and just feels sometimes; sometimes he keep things quite close to his chest. You don't like talking about it cos it upsets you and the problem is you don't want to bring it all back. After he see [doctor] it takes him a few days to settle down again. So [family worker] just sort of left it. She didn't help very much; she just dealt with what she had to deal with. She knew [key person] doesn't keep well. [Key person] doesn't like talking about that very much.

Family 3, partner

Well, for us in our family, we knew a lot about it, because like I said I have the condition myself or I had the condition {psychosis} myself, so we knew virtually everything about it. So in that respect, the {BFT} family meetings we didn't discuss too much about it {psychosis} because there was nothing new to find out because we knew already. I just don't think it's nice to always talk about it, I mean we all know it's there but it's not nice to focus on his {key person's} difficulties.

Family 5, mother

One participant stated that he did not think that the purpose of BFT was to discuss the key person's illness and expressed that it was not his place to seek this knowledge in the sessions, even though he also stated he lacked knowledge about his brother's illness.

That {talking about key person's psychosis} didn't really happen as much as the skill building and the family relationship building umm, I'm probably the one that's least in the know about all of that compared to everyone else. I'm probably very far down in the line for getting information, and I don't really mind, if that's what [key person] wants or whatever but I don't think that's what the meetings were for anyway.

Family 5, brother

Gaining information

Almost all participants from the remaining three families stated that they had an increased understanding of the key person's illness due to participation in BFT. This was expressed in terms of increased empathy with the key person's standpoint as well as increased knowledge of psychosis in terms of systems, possible reasons for onset and maintenance of psychosis.

And I think with the group work {BFT sessions} that was going on, that gave us a much bigger insight into what was happening with [key person] and her head and what the causes were, how it can happen, you know, the stress levels and whatever. So it kind of makes you understand what's going on in their head and what they're all about.

Family 2, mother

Some participants expressed a new optimism due to their increased understanding of psychosis through discussions in BFT sessions. They remarked on the role of the family

worker in explaining psychosis in greater depth compared to information received before BFT.

I think the way she {family worker} explained it and she had charts and all that, and she explained it in a lot more in depth than what the hospital did. Because it wasn't until [family worker] came with all the stuff and explained it all that I began to understand it and to see it in a different light. It gave me that wee bit of hope that you know, it can get better.

Family 4, mother

Three key persons described how they felt increasingly well understood by their family members. They observed that BFT had enabled their family members to understand their thinking processes through more open discussion and sharing the experience of psychosis.

But I think the family intervention did help with that because it helped highlight that I do suffer from this illness and it does affect my thinking and it does make me, change me in a way from the norm as it were, and that was brought to the attention by the family work, by my mum and by my sister during the sessions.

Family 1, key person

The other key person added that being understood made her feel closer to her brother. She reflected that past experiences of not feeling understood by her brother were directly linked to her not sharing or talking openly about her experience of illness.

I always thought he {brother} didn't understand me but I realised through the {BFT} family meetings that he didn't understand me because I wasn't telling him, like he was seeing stuff but he didn't understand it because I wasn't explaining it to him and when he tried to ask about it I got embarrassed cos like I thought he's not going to understand but he does, he's more mature than I thought he was. So we've got closer, which is really weird.

Family 4, key person

Subcategory 'problem solving'

The subcategory 'problem solving' was identified by participants as a main strategy of BFT.

'Problem solving' incorporated six themes which participants identified as having been

helpful in reducing the level of family conflict and tension. These themes are: 'communication style', 'active listening', 'immediacy and collaboration', 'accepting criticism', 'family worker as teacher' and 'reduction in conflict'.

Communication style

Participants stated that BFT helped them to identify and improve their communication styles, particularly with reference to problem solving. BFT was credited with enabling participants to reflect on the usefulness of different styles of communication and behaviour and also to practice alternative communication styles introduced by the family workers in the BFT sessions.

Communication about problems and detailed questioning related to problems were identified as useful strategies for problem solving discussed and practiced in BFT sessions, as well as introduced as strategies of BFT during planned family conferences or 'structured family meetings'. Structured family meetings were introduced as a main BFT strategy to all families (discussed in more detail in core category 3 'family togetherness').

And I, I keep going back to communication. Communication is the key. I think to probably, to most things in life. So, talk. Get things out in the open, and try and rectify them and there and then, having {structured} family meetings, y'know just sit and go through things, 'you got a problem?', bring it out in the open. 'What is it, 'have I done something wrong?' you know 'Oh, oh well, I thought you would've done that' and 'Well, you're probably right'.

Family 2, father

All participants identified an increase in talking or communication between family members due to participation in BFT. Participants highlighted both a greater amount of communication within the family (discussed in more detail in core category 3, 'family

togetherness'), and an improvement in the effectiveness of communication for problem solving through the practice of alternative communication styles in BFT.

I think it was um, what was the word, um...I think it was when we had to make the meetings {BFT sessions} and have the talks; we found that hard because we didn't ... We're weren't very good at like expressing ourselves, but things have got better, we practiced the talking, saying things properly so not just screaming about it. Like when I get [key person's] attention, I say "[key person] I want your attention" and I'm speaking to him, and you make your point over instead of getting angry 'cos he's not listening.

Family 3, partner

It was more just talking to each other, the way we {the family} talk to each other. How you come across, the tone of your voice and the way somebody might take that, you know, like sometimes the tone of your voice can be really abrupt without meaning to, and some people can take it the wrong way. Like instead of just coming out with "I want that done now" sort of thing, you would go about it in a different way and it would come out nicer, not as pushy.

Family 2, key person

Active listening

The opportunity provided in BFT sessions and structured family meetings to listen to other family members' thoughts and feelings about family relationships was acknowledged with gratitude by many participants. Participants highlighted an increased awareness of the importance of active listening skills, characterised as giving the other person time to speak and attempting to reflect on his/her opinion.

(sister): Um...one of the things we covered {in BFT sessions} was listening and that was very helpful to recognise that you need to give the other person time to speak and actually listen to what they were saying. And that was an effective tool because it made you aware that, it's hard to put my thoughts into words...

(researcher): So looking at listening...

(sister): And that would allow you to then follow that person's train of thought and where they're coming from...and it's a useful technique to have 'cos not a lot of people have that skill.

Family 1, sister

Alongside this, several participants also expressed how emotionally involving and difficult it was actively listening to the opinions and feelings of the others. Active listening was also regarded as a tool in changing behaviour in terms of spending more time together.

I think it {BFT} made you realise just how you kinda take each others' feelings for granted and you're not really listening to what that person's trying to saying to you. You think you are listening to it but there's so many other things that take over that you know, it makes it difficult. It does make a difference sitting down and talking about things. And it brings you closer as well as a family, just spending that wee bit of time together and talking about things.

Family 2, mother

It {listening} led to subtle differences in the way you communicate with each other, more getting behind what was really said to really hear what was being said. To challenge your own patterns of behaving.

Family 5, mother

Immediacy and collaboration

A distinction was often made by participants between the speed of problem-solving before and after participation in BFT. Through BFT sessions and structured family meetings, family difficulties were broached and solutions attempted with more immediacy, intent and focus than before.

The {structured} family meeting was quite important to us. Because it makes people's limitations come out quickly and then you are able to resolve it and sort it out or to know what to do when there's a problem, when things are not going according to what you want.

Family 5, father

We realised that hold on, y'know, that the problem being there, either resolve it now, because you can't let it go on and on, festering away, because it'll make it worse. And I think that everybody actually realises that now. And that's the difference.

Family 2, father

Participants pointed to a greater level of collaboration in problem solving developed through BFT sessions, with a sense that each individual had an equal and active role in resolving arguments and organising the household.

Like not all the time, but sometimes there was an argument and the two people would say well there is a solution to all the problems if you like agree on what you do when like, coz you can just get together and talk about things, about what you want to do and everyone gets a say in it, so that's what we do.

Family 5, brother

Yes, every single person got involved {in BFT}. Everybody now has the chance, or a place at the {structured} family meeting to talk about things, to air their grievances and what ever is bothering them...everyone now has a forum to talk about it formally, discuss it and thrash it about properly. Things are better now.

Family 5, mother

Within this, participants reflected that a key element in diffusing conflict was that BFT encouraged family members to address issues as a family unit rather than as individuals. As well as working as a family unit within the BFT session, participants noted that they had started to work more as a unit outside of the sessions.

We kind of try to work more as a team now {after BFT}, I think we are a team, we're good at that. You know, we sit down and organise all the different things that need to be done between us.

Family 3, key person

Accepting criticism

Dealing with criticism was highlighted as a key way to improve family relationships. Participants appeared to credit the reduction of tension through BFT with creating space for personal reflection on the causes of past conflicts, and developing the ability to take criticism from family members as constructive.

Well it {BFT sessions} reduced tension and friction and left me thinking that where are my points of contention with them, I realized that a lot of the arguments we've had in the past are about that I don't do much around the house. And I have to admit that I still don't. My mum looks after me a lot. And I think I have to change in the future and I think that's where she [my mother] and that's where [sister] has been critical. I feel now that I can step back from that now and accept the criticism 'cos I could just get up and help a bit more.

Family 1, key person

You know, it {BFT sessions} made me realise that, you know when you break it down, and maybe [husband] saying well you could have done it like this, that sometimes I could have handled things differently .

Family 4, mother

Family worker as teacher

The family worker was seen as a teacher and expert information provider. Participants portrayed the teaching method as relaxed and found teaching tools such as worksheets and charts to be useful.

As the weeks went on with [family worker] there was a difference because we were talking to each other and, you know, and it was the way [family worker] put it over, it was the way we asked each other not the sort of "you do the dishes you do this". It was 'would you do, please' or 'can you do this' and it was the way it probably re-educated us to the way we actually spoke to each other was really helpful.

Family 2, father

Well, I mean the skills that you were sort of getting from them, well most of them were sort of basic, but you were building on, you know learning to do it better.

Family 4, brother

A few participants drew attention to the introduction of role-play by the family worker as a means to practice different styles of communication. The use of role-plays was considered useful in terms of allowing each family member to become involved in BFT sessions. However, some participants said they found role-plays hard to master and described them as 'embarrassing' to carry out.

In some of the sessions we would [family worker] would do role playing with us. You know about what we would do in different situations, if we wanted to sort out an argument. It was really hard and a bit embarrassing I thought, knowing what to say next, but [family worker] would come in and help with different suggestions.

Family 5, brother

I got very nervous in the role-plays, I've got a nervous laugh and I laugh at the wrong times when I get nervous. And for the role-play, they were recording... I started to laugh. And they all started laughing. But it was good doing them because then [family worker] would go back and tell us what we did wrong, the way we were talking to each other.

Family 3, partner

Many participants ascribed their increased ability to deal with family related problems partly to the presence of a third party (the family worker) who, having been regularly involved in family discussions, helped participants to view their situation in a fresh way.

I think it was just nice sitting down as a family and having somebody else...if you're sitting down just the three of us, you're more than likely to have an argument. But because there was somebody else there, she could say 'we'll stop there' and move onto something else and discuss that. So it can't get really heated and things get discussed instead of things going too far.

Family 2, key person

I think probably just the way [family worker] just came over just to trying to explain to us how to go about things, eh? How we didn't think before about shit. I used to be shit and get in to trouble with that shouting, or, um, [family worker] would say there's a way to ask people.

Family 3, key person

Reduction in conflict

The theme 'reduction in conflict' refers to participants' understanding and experience of conflict within their family environments before and after participation in BFT. Participants described arguments as a significant part of their family relationships before BFT and many felt that the severity and frequency of arguments had reduced as a result of participating in BFT.

I still shout. I'm not saying I don't shout, I still shout, but nothing compared to what I did before {BFT}. I think it was just the fact that [key person], well he's still got a temper, he still loses his rag. I know he doesn't mean it. Just get by in life and try and get through things without too much animosity. We still argue but not to the extent we were before {BFT}.

Family 3, partner

Some participants reflected that the process of participating in BFT gave them the perspective to realise there was a disparity between the low-level triggers family arguments, for example about household chores, and their often severe escalation. This realisation stemmed from a comparison, encouraged by the family worker, of the kind of arguments BFT before and after BFT. Though arguments continued to be accepted as 'normal' part of family life, after BFT, they declined in seriousness and intensity.

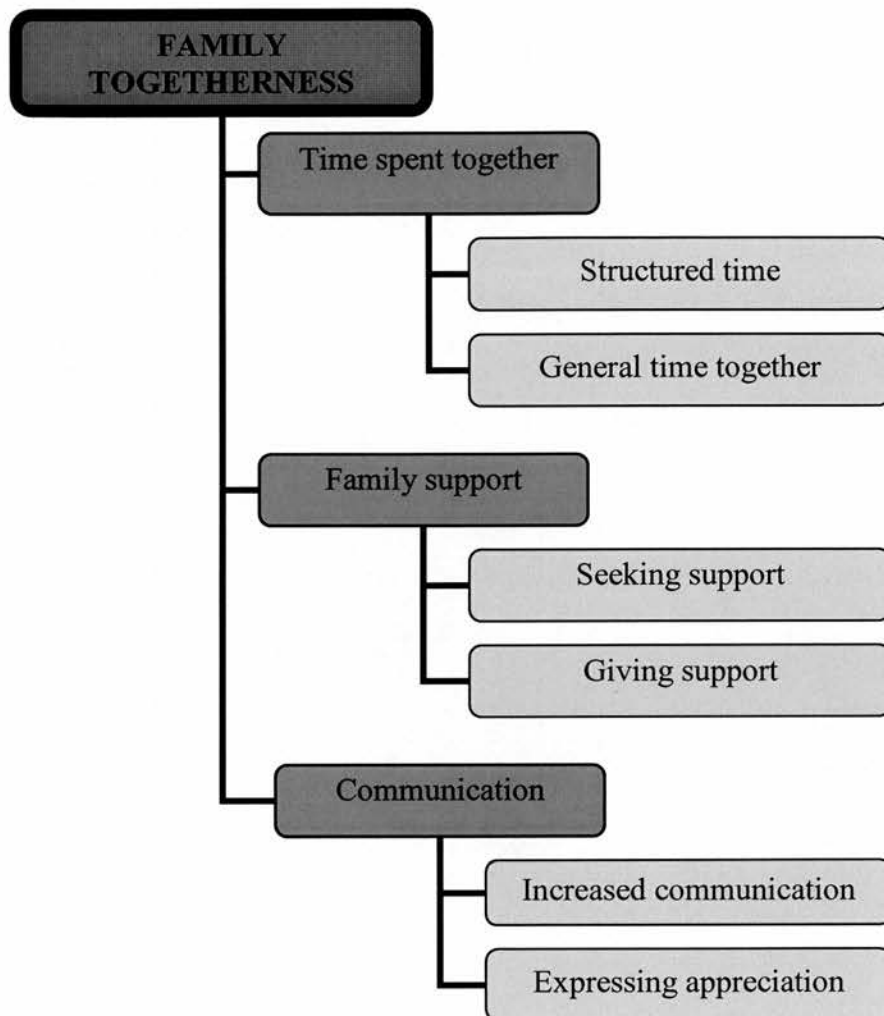
So there were always squabbles about who's not doing their chores, who's not doing stuff, you know, clashes you know, clashes, people going out late at night, not coming back at the right time, all sorts of things. Normal family issues, I thought they were... Well before {BFT} they would turn into arguments, really big serious arguments with police involvement. I'm not joking at all, it was really, really bad. The police would have to come in and sort it out. But now we don't have things like that, it's been a real big improvement.

Family 5, mother

3.2.3 Core category 'family togetherness'

The core category 'family togetherness' is made up of three subcategories: 'time spent together', 'family support' and 'communication'. These subcategories are further divided into themes (see figure 4).

Figure 4: Core category ‘family togetherness’



Subcategory ‘time spent together’

The subcategory ‘time spent together’ is divided into two themes ‘structured time’ and ‘general time together’.

Structured time

Most participants stated that one of the key elements of BFT was the introduction of regular 'structured family meetings', which they described as regular pre-organised occasions when family members would meet to discuss problems and general household organisation.

Participants viewed these meetings as having a powerful impact on building relationships and perceived spending more time together as positive. Participants in four of the families mentioned that they had had no 'structured' family time together prior to BFT.

Yes, because I don't think we ever used to really, because before {BFT} we never really sat down as a family and talked about things as such. You know it was always just like...things would happen, you just didn't spend enough time, everyone's always so busy now. You just didn't give that wee bit of extra time to try to sort things out, you know if you could see things going wrong or before it multiplied into a full blown argument or whatever.

Family 2, mother

From time to time she {family worker} introduced one new concept to us which was the concept of {structured} family meetings, which is one thing we do now, now and again. When things are getting to a head in this house we call a {structured} family meeting and even when things aren't getting to a head, from time to time we have a {structured} family meeting where we all gather and talk about what has happened since the last meeting and what's going on now, what's happening in the house right now. If any one has any agro and problems we bring it forward and talk about it and if anything big is going to happen we discuss them at the {structured} family meeting and everybody will share their views, what they think about it. That has been a very, very big thing in the house.

Family 5, mother

Participants from one family (family 4) expressed a different attitude to structured family meetings compared to other participants. Structured family meeting was something that was already routinely practiced within that family before BFT. They attributed less impact to structured family meetings in BFT sessions than the other families did. However, three out

of the four participants from this family identified some differences to family interactions because the new structured family meetings now focused more directly on resolving difficulties, as compared to a previous focus on routine family decisions such as holidays.

I found it quite helpful because it enabled us all to say what we were thinking and it was good with [family worker]. We do sort of have little family meetings anyway but probably about lots of other things rather than just to do with [key person], just lots of things so yes, I think we found it quite helpful because we could talk about you know if there was something we were worried about. We could bring it up and we got to know each other a lot better.

Family 4, mother

Well, I think they were {family workers} surprised because we've always had family meetings. They were surprised because they'd never had a family like ours before. So I don't think the {structured} family meetings were new, but they did let us focus more on some of the arguments between [key person] and mum whereas before they would be more about general stuff, where we were going on holiday and discussions and things.

Family 4, brother

The remaining participant in family 4 felt there was no change in the content of their family meetings as a result of BFT sessions and perceived not added benefit from the new structured family meetings.

We're always called family meeting, ever since the children were little so the {structure} family meetings introduced by [family worker] were nothing new really.

Family 4, father

General time together

Through the process of participating in BFT, many participants observed that there was an increase in the amount of time family members spent together. This was partly attributed to time spent together in BFT sessions and structured family meetings, and partly attributed to more general time spent together in a casual way. For example, participants described

spending more time together going for coffee, eating meals together, watching television - and in one family watching *less* television, to allow more time to talk to each other.

Plus I spend more time with them {parents} whereas before {BFT sessions} you'd find me in my bedroom watching television, watching exactly the same programme as they were watching at the front...now I'll go through and I'll be like I want to watch this would you like to watch it with me? And I'll sit with them and watch it.

Family 4, key person

Through the BFT process, several participants perceived that the key person within the family wanted a more cohesive family, which further increased commitment to spending time together.

Because we did it, yeh, because I think [key person] was wanting more of a family unit, so she knew we were behind her.

Family 2, mother

Subcategory 'family support'

The subcategory 'family support' is divided into two themes: 'seeking support' and 'giving support'.

Seeking support

Many participants indicated that through participating in BFT sessions key persons felt increasingly able to seek the support of their family actively. Seeking support was described in terms of the key persons' increased willingness to talk about their problems and feelings, both during and outside BFT sessions.

In particular, participants described the positive impact of discussing triggers that caused the key person to feel unwell or upset. This provided a shared understanding of the key persons' experiences.

But even, like, with my brother, whereas before {BFT} if I was struggling I'd hide in my room and stay there, whereas I think it was last week I wasn't doing very well, usually I'd sit in my room and just like cry or get angry or something, you know what I mean, but instead I just went through and talked to him and it helped, which was weird, yes it was good, it was different.

Family 4, key person

So we discussed triggers and [key person] now comes and tells us when he's feeling bad.

Family 1, sister

Giving support

Participants pointed to an improvement in family supportiveness throughout the process of BFT and a growing sense of the family as a tighter and more supportive 'unit'. Giving more support to family members was considered to be in part due to the increase in time spent together, allowing for the family to become 'closer together'.

It {BFT} was helpful in the sense that it brought the family closer together...um it was very supportive, I found. Um... if there's something in the family that's of concern to one member of the family, it's helpful to have the family rally round to support them, so that they feel they've got some safety net and they're not isolated.

Family 1, sister

(researcher): Do you think that affected your relationship?

(partner): Oh, ay, definitely. Definitely

(researcher): In what ways? Can you tell me a little bit about that?

(partner): Well I think our attitudes to things have changed. You know, not taking things for granted...doing more together as a team things have definitely got better between us.

Family 3, partner

Subcategory ‘communication’

The subcategory ‘communication’ was divided into two themes: ‘increased communication’ and ‘expressing appreciation’.

Increased communication

The theme ‘increased communication’ is linked with the subcategory ‘time spent together’. Participants described increased communication with family members, due primarily to spending more time together. The theme ‘communication styles’ within core category 1 ‘conflict & problem management’ identified improvements in participants’ communication approaches, specifically to problem solving. However, the present theme ‘increased communication’ differs in emphasis as it reflects a perceived increase in more general communication.

What’s been a real change I think is that we talk more, making sure we have enough time to talk to each other. Not always about the problems but about everything or anything, you know.

Family 1, sister

(...) we were sitting on Sunday and have a good yap. We just all get together, the four get together and we all have a good yap. And we’d talk about whatever, whatever the subject happens to be, as a team. I think we do work more as a team now than we ever did before.

Family 3, key person

Expressing appreciation

Participants noted an increase in expressions of appreciation, gratitude and kindness though addressing positive communication styles in BFT sessions. All participants felt that saying ‘thank you’ greatly improved communication. Increased frequency of thanking other family

members was directly linked to BFT and had a positive impact strengthening the relationships.

So, one of the things talked about was a whole session about saying the word 'thank you' and using the word properly in things that people do for you and it struck me suddenly that this is not something we do.

Family 4, father

(...) because there were many other things [family worker] taught us, like how to communicate. How to say things nicely to people... many things like that, you know, talk to people nicely and umm then if somebody has said something to you or done something for you and it was good, you should go back to the person and say to the person "well you know what you did, that was very, very kind of you and I just want to let you know that was very kind to you". You know things like that, what I call basic, basic politeness that we take for granted and we don't think that we need to do, but it {BFT} taught us those things, very positive things. Ways of life I call it.

Family 5, mother

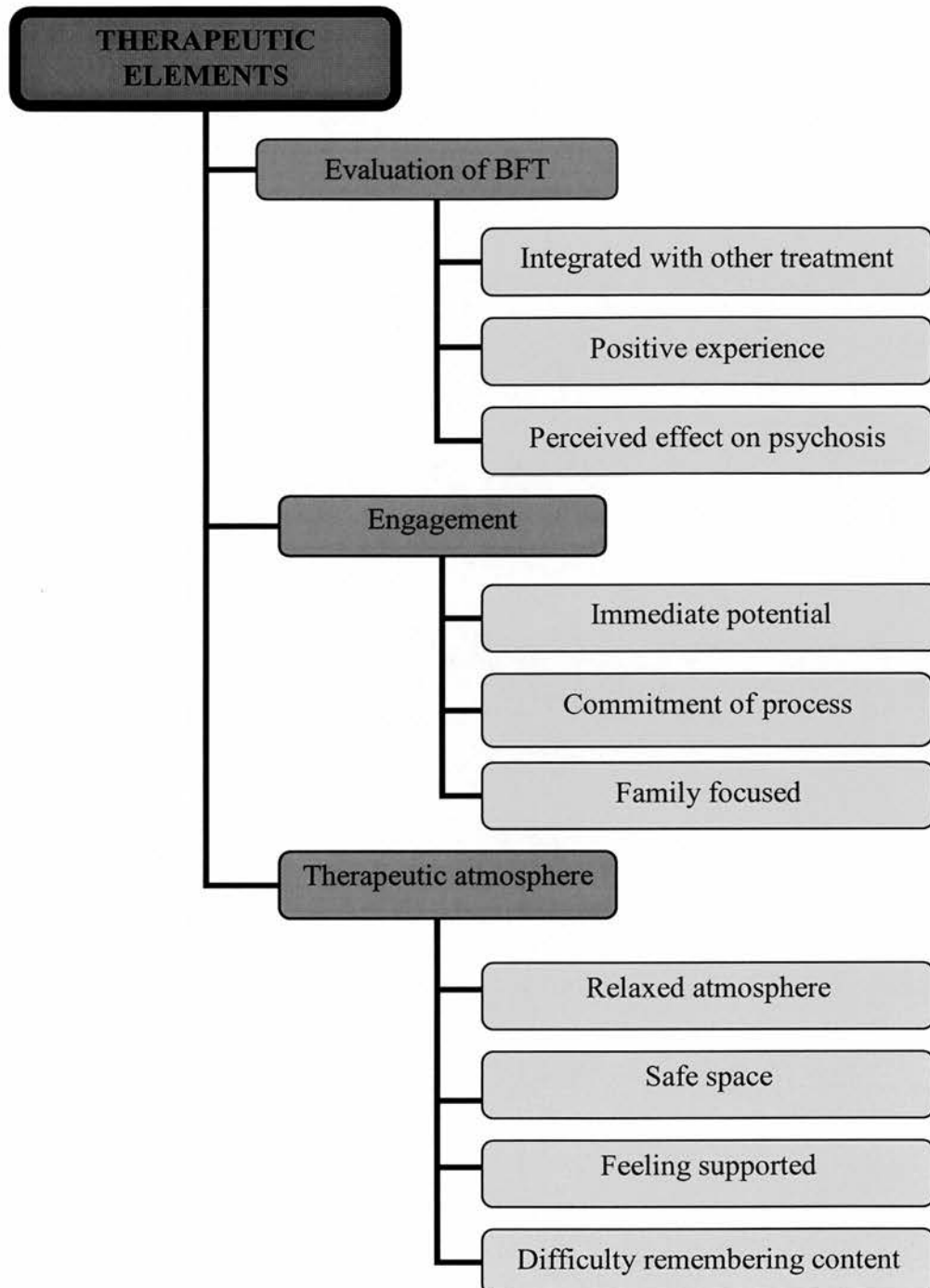
3.2.4 Core category 'therapeutic elements'

The core category 'therapeutic elements' is made up of three subcategories: 'engagement', 'family focused' and 'therapeutic atmosphere'. Subcategories were further divided into themes (see figure 5).

Subcategory 'evaluation of BFT'

The subcategory 'evaluation of BFT' has three themes: 'integrated with other treatment', 'positive experience' and 'perceived effect on psychosis'.

Figure 5: Core category ‘therapeutic elements’



Integrated with other treatment

BFT was viewed by participants as a treatment within a wider package of psychiatric care being offered, notably medication and CPN support, and in one case clinical psychology input. Participants described their experience of having received BFT within this context and described the perceived effects of BFT as integrated within this wider package of care, as opposed to separate from it.

Two differing perspectives emerged concerning the perceived effects of BFT sessions in relation to other treatment. In one perspective, BFT sessions were considered to impact directly on improving family relationships, whilst the positive effect of medication was acknowledged. In the other perspective, participants described difficulty in separating the effects of BFT from other treatment received. Within both perspectives participants implicated the family as a whole, rather than just the key person, in accounting for the improvements in the key person's mental health.

But what's happened now is that we as a family have become able to be more and more a family. The family sessions really helped with that, I mean, that's part of it, but it's not like cause and effect. The medications that [key person] has been on, he's chosen the last one himself and that's made a tremendously big difference.

Family 1, mother

It's not easy to judge what has helped him {key person}, but actually he hasn't had any episodes since the last time he was in hospital so obviously whatever we {the family} are doing, we are doing the right thing, so I hope we keep doing whatever it is that is keeping him out of hospital. Whatever it is, {structured}family meetings talking, medication. Whatever it is that we are doing, I hope we keep doing it so he keeps out of hospital.

Family 5, mother

Positive experience

All participants described BFT as a positive experience for themselves individually or in terms of perceived benefits for others in their family. This sentiment was marked very strongly within most of the participants' narratives. Most participants described their experience of BFT as supportive, helpful and having a significant impact on family life.

I've got to say, everything was geared up to make things better. So I couldn't say there was any, any area at all that was unhelpful y'know so...everything, for us was looking forward. Y'know, taking it a bit, from the stressful point there {onset of key person's illness}, forward to make things better.

Family 2, father

It {BFT} is a very, very good thing, a positive thing. If I was to have my way, I was to say to the MP {minister of parliament}, I would say make sure every family whether you think you need it or not, just make sure everybody should have it {BFT}. If you had to employ people to go to every single family honestly it's that important.

Family 5, mother

In describing BFT as helpful, several participants went on to place particular emphasis on the perceived benefits for others in the family, namely the key person and main carer within the family. These participants described BFT as having the most impact on the members of the family that were most closely involved with the key person.

I think [key person] got a lot out of it and he was really glad that we {mum and sister} took part {in BFT}. He got more out of it than probably I would have because it's very personal to him. I would always want [key person] to, if there was anything that would help, that would be some benefit, that we would want to take advantage of rather than not.

Family 1, sister

One participant described how the experience of receiving BFT had not been helpful or useful for himself personally because he felt skilled in the area of conflict management. However, he acknowledged that BFT sessions benefited other family members.

Its difficult to speak for the rest of the family but what I can say for myself, I didn't find it extremely useful I didn't find it either way, productive or counter productive, but [wife] and [key person] probably did, I think they did find it beneficial.

Family 4, father

Perceived effects on psychosis

This theme refers to participants' perception of the impact of BFT sessions on psychosis and must be understood as linked to the subcategory 'BFT within a wider package of care', since participants received BFT in conjunction with other treatments.

Three of the four key persons felt that BFT sessions had not directly impacted on their experience of illness due to persistent symptoms of their illness during such as paranoia and hearing voices. They described BFT sessions as enabling other family members to better understand their personal experiences of illness and stated that this resulted in reduced tensions within the family environment.

It helped with my temper. But I don't think it helped with the drinking or the illness side of things, I still see the doctor and am on medication, lots of medication. Sometimes my mind is full of all sorts of things, it's difficult for me.

Family 3, key person

I was unwell at the time {of BFT sessions} and I was on medication, it was hard, I don't think [family worker] helped me, I just think it just helped in bringing us together as a family more, really.

Family 2, key person

One key person gave a different view from the other three key person participants in that she described how communication skills learnt in BFT sessions had had a direct effect on her mood. This key person stated that BFT had enabled her to alter her evaluation of family conflicts. She explained that through the process of BFT sessions she was better able to manage criticisms directed at her to prevent them from impacting on her mood.

Because the fights with mum would set off some of my problems after a fight with mum, I would get really depressed or if mum said something to me about my weight it would just start to go round in my head, whereas now {after BFT} I can stop it and know she didn't mean it that way.

Family 4, key person

Subcategory 'engagement'

The subcategory 'engagement' is made up of three themes: 'immediate potential' and 'commitment to process' and 'family focused'.

Immediate potential

Many participants were initially apprehensive about participating in BFT but engaged with the process early in the sessions, partly due to the perception that BFT had the potential to benefit them and their family as a whole.

Some participants stated that their initial reaction to BFT was that it would be unhelpful or irrelevant to them, since they did not perceive their difficulties to be related to the family. However, these participants stated that their initial pessimism was reassessed in the early stages of BFT. The perceived immediate potential of BFT to improve their situation appeared to give validity to the therapy very quickly for the participants involved.

Well at first I did feel a bit awkward, I have to say you feel a little bit silly, but you realize that there's something in it {BFT} that's going to improve your own situation, to help me with the illness I'm suffering. And I generally take things to do with that quite seriously because I want to improve and to move on. And how did I feel about it? I didn't really know what it was; I thought, you know, "family intervention, yeah right?" Just tell them, "Just leave me alone," kind of thing. But it wasn't bad, [family worker] wasn't critical. But I realise now that my family can actually be helpful towards me and I can be helpful towards them by getting better, letting them see that I can have a better quality of life than I did.

Family 1, key person

At first I was, like I said, I wasn't very keen about it {BFT}, I just thought it was normal squabbles, people {family worker} are just coming to disturb us in are house, but when we started it I could see the difference and by the end of the whole thing I found it most useful, most useful. Because it has helped us to, the work {BFT sessions} helped us to find ways of getting around issues in this house.

Family 5, mother

Participants in one family did not feel initially engaged with BFT as a specific therapy, but were encouraged by one member of the family to try it as a new or alternative treatment. For this family it appeared that there level of engagement with BFT was less linked to the potential of the intervention compared to other participants and more linked to the introduction of BFT as an alternative treatment.

I think I was actually a part of it, to get us to do it because I remember mum and dad and [key person] saying that there was this thing {BFT}, an opportunity to try something out, something new. And I actually said, well 'lets try it' although we've had some bad experiences that have happened, it would be good to give something else a shot and see if it helped rather than close everything off, and I think it did as well.

Family 4, brother

Commitment to process

Some participants ascribed importance to the fact that they had made a conscious decision to participate in BFT. They felt that the act of committing themselves to a gradual programme of therapy, rather than avoiding the existence of problems or passively waiting

for improvement, had itself contributed to their active engagement. Participants considered regular BFT sessions over a period of time to be an effective format for focusing attention on difficulties within the family that had not been actively addressed prior to their participation in BFT.

(...) because it was spread across a period of time and we all committed to it, we did commit and did do it, it meant that we consciously dealt with something, dealt with [key person's] illness and we were able then to admit to ourselves the feelings we had.

Family 1, mother

The role of the family worker in the engagement process was seen as important. Participants stated that they perceived the family worker as a constant in their lives, who regularly visited the family and prompted participants to engage actively with the process, including practising strategies that had been discussed during sessions.

I think the fact that [family worker] came and spoke to us, um... made us realise just how beneficial this was to us. If she hadn't come to us, we probably won't have, we felt we had homework to do, it's like being at school in a way, and it made us do something or we would have just pushed it aside, I think we would have. But the fact we knew [family worker] was coming to see us, so we had to do the homework.

Family 3, key person

Family focused

Family member participants valued the acknowledgement from family workers that the key person's illness had had an impact on the whole family, because this validated their own perceptions. For many, it appeared that the impact of psychosis on the family had not been addressed directly before by services or interventions that they had received.

What was really good was how [family worker] were with us, she understood how [key person] becoming so ill had really effected everyone in the family. She really understood

what we were going through because when [key person] was in hospital they were brilliant but we didn't feel as involved, no one was looking out for us as well.

Family 2, mother

And I still feel emotional about that because to me that was really, really important, um yes. Because there was someone {family worker} who was really, really helping in a different way. And I don't want to sort of say anything about the nursing staff, because over the years that [key person's] been ill we've had tremendous CPN support, but here was somebody who had a different slant on things and was accepting that the illness that somebody suffers from has ripples that spread a long way through a family.

Family 1, mother

Subcategory 'therapeutic atmosphere'

The subcategory 'therapeutic atmosphere' was divided into four themes: 'relaxed atmosphere', 'safe space', 'feeling supported' and 'difficulty remembering content'.

Relaxed atmosphere

All participants stated that they felt comfortable in the therapeutic environment as a direct result of the family workers' qualities. These qualities were described as being friendly, having a natural style and a positive, concerned attitude. Participants placed importance on these qualities as it allowed them to feel relaxed and engaged in the process of BFT.

And they were quite chatty before it as well, so that sort of relaxed us, which was nice. So it wasn't as bad as you thought it would be. But it sort of eased into, in a nicer way, more relaxed, and it wasn't intrusive in any way either. It just felt sort of natural, just having someone come round to talk to you, and at the end they would stay and chat to you, so the social bit of it helps.

Family 4, brother

I say [family worker] because it was [family worker] who was here with us most of the time, I think she was absolutely magnificent. Her attitude was good, err, she'd become a friend. Which is... psychology being what it is, you're friends, in effect. And she does become a friend, it's true. So, it made it easy to talk and that helps. If you find somebody easy to talk to, y'know it's quite stressful and all, you can be open.

Family 2, father

Safe space

BFT was carried out in the family home and many participants described this as a 'safe space' in psychological as well as physical terms. Having sessions at home appeared to be comforting to participants, despite some participants' initial reservations about the family worker coming to their home.

It was nice having [family worker] coming here {in the home} because with [key person] obviously having to go away and get ready and feel like he was a genie pig in an office or a surgery or something. It was a more informal kind of atmosphere which obviously makes you more relaxed, hopefully.

Family 1, sister

The fact that it was held at my house made it easier for me. At first I wasn't sure 'cos, like, my house was my space, like it feels OK when I come here - well it's your house, yes it's my house so I wasn't too sure about it at first but it was more relaxing being at the house.

Family 4, mother

You could say stuff, but it {the family work} was like having a safe zone to say stuff in the house.

Family 5, brother

Family workers were described as taking a leading role in clarifying how family discussion could move forward. The family worker was perceived as committed to and in control of BFT sessions, making participants feel safe to explore emotions within the family.

But the comforting thing about it {BFT sessions} was that you were not in control of it, [family worker] was in control of it. And he took that responsibility and that commitment to enable the emotions to be allowed and that, to have that safety for that to happen enables learning, in my opinion, learning to move forward. It's like a captain of a ship, they take the responsibility and you're able to get on with something that if that person {family worker} wasn't there you won't be able to do, kinda thing.

Family 1, mother

So now we feel more comfortable, we can sit there and tell her {family worker} what we think and don't feel too bad to say something that you might feel stupid about, I don't feel

uncomfortable in {family worker} company to say things but in the past I've maybe been with other professionals and if you don't take to somebody then its quite difficult.

Family 4, mother

Feeling supported

The theme 'feeling supported' is related to the subcategory 'family support' (within core category 3 'family togetherness'). Participants identified feeling supported by the family worker. There were two aspects to this theme: the first was feeling actively supported through regular contact with the family workers; while the second was feeling comfort in knowing that support would be available outside sessions if participants asked for it.

We looked forward to them coming to the house to meet with us, you know, to at least have maybe another thought in what is going on for us, I mean, it made things easier for us, and given that it was a very difficult period in terms of [key person's] illness and everything, it made things easier for us.

Family 5, father

They were there for us. It gave us the confidence to go through with what we went through, knowing if anything happened we could pick the phone up and somebody was going to help us.

Family 2, father

Difficulty remembering content

Many participants mentioned that they had difficulty remembering the content of BFT sessions in detail. They were better able to discuss how the experience of BFT had made them feel generally and the effects it had had on their family. This theme did not appear to be dependent on the length of time since completion of BFT, as it emerged from the narratives of participants who had recently completed BFT as well as the narratives of those who had completed BFT over a year before the research interview.

But we had quite a lot of meetings and I've got my diary, I mean I could, I've got all my diaries for years upstairs. I could go back in detail of what the pattern of meetings were but the content of the meeting of course I couldn't, because again when you're actually in it you're not logging what is happening, you are just free to be able to speak.

Family 1, mother

We covered a lot of things over the week {of BFT sessions}, it's hard to remember a lot of it. [Family worker] brought sheets for us and we would work through them. It was mostly about the way we talk to each other and talking about problem-solving, about the arguments with me and mum.

Family 4, key person

3.3 INFERRED RESULTS

This section presents an analysis of the descriptive results (core categories). Three main inferred results are presented: firstly, the commonality or shared experience between key persons and other family members; secondly, participants' perception of the main gains or outcomes of BFT; and thirdly, participants' perception of the processes involved in BFT. The first inferred result stems from a comparison of the categories and themes that emerged from the narratives of BFT participants; the remaining two inferred results stem from a comparison of the categories and themes with the literature base. Based on the descriptive and inferred results, a hypothesized model of the mechanisms involved in BFT is proposed.

3.3.1 Shared experience

Within the themes and categories generated, there was a striking commonality between the experiences described by key persons and those described by other family members. This shared experience of BFT directly impacted on the analysis of individual narratives,

resulting in the emergence of key themes early in the research process. In some cases, participants indicated an awareness of the commonality of experiences, but in most cases they did not. Nonetheless, the narratives showed strong correspondences both within and between families. The chosen method of individual interviews (with one partial exception, examined in the discussion (section 4.3.3), meant that the effect of group dynamics within the interview process could be excluded from analysis.

The main implication of this shared quality of participants' experiences is that it supports the notion of the family unit as the *participant* of BFT, rather than a collection of family members assisting in a therapeutic process directed at the key person. A key indicator of this was the tendency of families to act as if the primary problem for which they were undergoing therapy was family dysfunction, rather than a psychotic syndrome located in the key person. At least in their thinking about BFT, they did not appear to follow the traditional medical model of illness that pathologises patients and separates their experience from that of their families. Rather, their reasoning and intuition about the nature of the process seems better accord with the vulnerability-stress model of psychosis (Mueser & Glynn, 1999; Nuechterlein *et al.*, 1984; Zubin & Spring, 1977), which situates psychosis always within a social context.

In the vulnerability-stress model, stress is a potential trigger of psychosis and relapse. Stress can be caused by tense relationships, emotionally charged environments and interactions with hostile or critical people. The emphasis of both key persons and family members on BFT's success at improving relationships, reducing tension and making family

interactions less abrasive suggests that they attach similar importance to the social dynamics of the family. Likewise, the value attached to increased family support as a result of BFT echoes the importance of 'protective factors' in the vulnerability-stress model, which are claimed to counteract the effects of stress and other aggravating factors.

However, unlike the vulnerability-stress model, which sees all these factors from the perspective of the propensity to relapse, it was not obvious that participants were seeing the BFT process and its results in these terms. This is further explored below.

3.3.2 Perceived outcomes

What counts as an outcome of BFT?

Participants described the experience of having received BFT as overwhelmingly positive (theme 'positive experience' within core category 'therapeutic elements'). This supports Campbell's (2004) qualitative findings that participants were very satisfied with the BFT they had received.

BFT has been formally evaluated through outcome in research studies. The main outcome is considered to be a reduction in the rate of relapse and much of the literature base focuses attention on this (e.g. Dixon & Lehman, 1995; Falloon, 2003; Pharaoh *et al.*, 2007). Surprisingly, however, the topic of relapse did not develop as a theme or category within this study.

Clearly, the intended outcome of reduced relapse need not be expressed directly by the participants in order to be present or desirable. Nevertheless, its absence as a primary motivating factor or outcome requires investigation. There are a number of factors specific to this study that may explain the lack of discussion about relapse. Most obviously, this study did not directly investigate relapse or draw participants' attention to it. Furthermore, two of the families (families 4 and 5) participated in this study shortly after completion of BFT (one month and two months, respectively) and so there was only a limited time for the possibility of the key person suffering a relapse.

Of the three families that had completed BFT over twelve months before participating in this study, one family (family 2) described how the key person was no longer unwell and had recently stopped medication. The remaining two families (families 1 and 3), where both key persons had longstanding diagnoses of schizophrenia, described that psychosis was still present. Nevertheless, whatever the key person's status with regard to relapse, it might have been expected that avoiding or alleviating it would have been a primary motivation for embarking on BFT.

In the theme 'effect on psychosis' (within core category 'therapeutic elements') participants expressed opinions on the direct effect that BFT had on psychosis, with two out of the three key persons viewing BFT as not having an effect on psychosis. Similarly, other family members did not attribute BFT as impacting on psychosis and instead place emphasis on other treatments such as medication reflected in the theme 'integrated with other treatment' (within core category 'therapeutic elements').

Another possible explanation for the lack of emphasis on relapse in participants' narratives is that it was not the main perceived gain of participating in BFT. This leads to the second inferred result, namely that the gains described by participants which have typically been understood as strategies of BFT to decreased relapse rates were perceived as gains or outcomes in their own right, relevant to the general well-being and health of the patient and the family. This appears to be related to the first inferred finding, the commonality of experiences between key person and other family members, and the sense of the family unit being the patient. If the family members feel they are all undergoing the therapy, then it is less surprising that the hoped for outcomes are not confined to the mental health of the key person.

Participants' perceived gains

The main perceived gains were reflected in core categories 'conflict & problem management' and 'family togetherness'. In summary, the main perceived gains of BFT that participants identified were:

- Reduction in family conflict and problems
- Increased understanding
- More supportive family unit

The perceived gains could be viewed as the key effective elements of BFT that help protect against relapse or could be understood as outcomes in their own right, irrespective of, or in addition to, their impact on relapse. Each perceived gain is discussed below.

Reduction in family conflict and problems

A key gain perceived by participants was the reduction of arguments, tension and problems within the family environment (reflected in core category 'conflict & problem management'). This was expressed by participants as a value in itself rather than as a tool to fight against illness. This finding shows similarities with Campbell's results (2004) that showed that a reduction in carers' stress associated with looking after an ill relative was perceived as a primary gain of BFT. The findings of the present study appear to expand on the causes of stress highlighted in Campbell (2004), especially regarding the evaluation of psychosis as a main cause of family tension and conflict (subcategory 'psychosis as cause of conflict' within core category 'conflict & problem management').

The constructs of EE ('criticism', 'hostility', 'emotional over involvement (EOI)' and 'warmth') (Brown & Rutter, 1966), have been dominant in the research on the effects of family environments on psychosis. Tentative comparisons of participants' descriptions of family behaviours with these constructs can be made, although they did not emerge as dominant or significant themes within participants' narratives. Some participants made references to critical others and hostile others in the family (in descriptions of both key persons and other family members' behaviours in conflicts and arguments), though few described themselves explicitly in that way. EOI was implied by some family member participants, not about others but in reference to themselves, when describing feeling overwhelmed by the key person's illness and over-protective communication styles.

Increased understanding

The theme 'gaining information' (within core category 'conflict and problem management') captured the experience of participants from three families that they had expanded their knowledge and understanding of psychosis through BFT. This is in keeping with the emphasis placed on psychoeducation as a tool within BFT practice (Falloon *et al.*, 2004).

Increased understanding was perceived by participants in terms of knowledge gained but also in terms of increased empathy and appreciation for the key person's individual experiences of illness. This appears to be linked with the theme 'avoidance' (subcategory 'identifying problems' within core category 'conflict and problem management'), which reflected participants' difficulty broaching or getting to the bottom of problematic patterns of behaviour within the family due to fear of not being able to contain the key person's reactions.

The appraisal and understanding of psychosis by participants as something either internal to or separate from the key person may be an essential factor in understanding the avoidance and communication patterns identified through participation in BFT as a source of increased conflict within families. Within the literature, both levels of EE and carer burden have been found to appear more dependent on individuals' appraisal of patients' problems than on patients' actual deficits (Raune *et al.*, 2004; Scazufca & Kuipers, 1996; Smith *et al.*, 1993).

However, the findings of this study do not fully correspond to the branch of EE literature that suggests that relatives with high EE showed a tendency for causal attributions that make the individual responsible for his/her symptoms (Barrowclough *et al.*, 1994; Brewin *et al.*, 1991). Rather, the present findings suggest that participants experience confused or fluctuating appraisals of psychosis as sometimes external and sometimes internal to the key person reflected theme 'psychosis as cause of conflict' (in the subcategory 'identifying problems' within core category 'conflict and problem management').

One possible hypothesis is that not knowing whether to attribute the causes of behaviours externally or to the illness of the key person is itself a contributing factor to high EE and a cause of conflict identified by participants during BFT. Patterson and Birchwood (2005) have questioned whether EE is a stable concept and also whether low EE might in fact be an 'abnormal' reaction to psychosis within the family. If levels of EE within most families are high some of the time, it may be that where one member of the family has psychosis, the difficulty lies in EE remaining at a constantly high level due to family members' fluctuating appraisals of psychosis.

The fluctuation of appraisals of psychosis might be stressful in itself, leading to high EE or it might be that when family members situate the psychosis within the key person, they are more likely to blame, criticize and be hostile towards him or her. Whereas, at the times when family members perceive psychosis to be something external which is affecting the key person, they are more likely to respond with EOI and warmth; suggesting that how ever family members appraise the key person's psychosis, levels of EE of one form or another

remain consistently high. This would conform with Barrowclough and colleagues (1994), who found that high levels of criticism and hostility appraisals of psychosis as personal and controllable, whereas high levels of EOI were correlated with appraisals of psychosis as impersonal and uncontrollable.

Whatever the possible causes of high EE, it can be tentatively inferred from the themes within the core category 'conflict and problem management' such as 'psychosis as cause of problems' (within subcategory 'identifying problems'), 'communication style', 'accepting criticism' and 'reduction in conflict' (within sub-category 'problem-solving') that the participants did tend to have high EE characteristics prior to the BFT and that, through strategies identified in core categories 'conflict and problem management' and 'family togetherness', these EE characteristics became less prominent.

More supportive family unit

The perceived improvement in family support and family unity can also be interpreted as a main perceived outcome (reflected within core category 'family togetherness'). The impact of the EE constructs of 'warmth' and 'positive comments' has had considerably less attention within EE research compared with the constructs 'criticism', 'EOI' and 'hostility' (Barrowclough & Hooley, 2003). However, participants placed great importance on the development of supportive family relationships, feeling and showing gratitude and positive communication styles.

This supports the notion that high levels of ‘warmth’ have been associated with good outcomes (Brown *et al.*, 1972). The present study’s findings indicate that participants’ experience of expressions of ‘warmth’ reflected in the core category ‘family togetherness’ could be viewed as no less important a factor than ‘criticism’, thus counterbalancing the emphasis of past research on EE as a predictor of dysfunctional family behaviour.

3.3.3 Processes in BFT

BFT does not work simply as a didactic therapy in the treatment of psychosis. Falloon (2003) argues that psychoeducation about mental illness is a valuable aspect of family interventions however, “it does not seem sufficient to reduce the risk of major episodes or to promote clinical and social recovery” (Falloon, 2003, p25). Rather, BFT uses therapeutic processes or ‘tools’ to acquire and enhance skills for dealing with psychosis and family dysfunction.

The core categories ‘conflict and problem management’ and ‘family togetherness’ can be understood as tools of this kind. Examples include the subcategories ‘problem solving’, ‘family support’, ‘communication style’, ‘active listening’ and ‘time spent together’. Alongside these, the subcategories ‘engagement’ and ‘therapeutic atmosphere’ within the core category ‘therapeutic elements’ can be interpreted as a significant dynamic within BFT identified by participants. Taken together, the processes involved in BFT can be understood as an interplay between ‘therapeutic elements’ and the ‘tools’ of BFT.

The development of the core category 'therapeutic elements' highlights the importance participants place on non-didactic and skill-based strategies within their experience. It shares the key components of the theoretical construct 'therapeutic alliance'. 'Therapeutic alliance' is defined broadly as the collaborative and affective bond between therapist and patient (Rogers, 1956). Definitions of therapeutic alliance vary but most share the following three aspects: the collaborative relationship between the patient and the therapist; the affective patient-therapist bond and the ability of patient and therapist to agree treatment goals (Bordin, 1979; Gaston, 1990; Horvath & Symonds, 1991; Saunders *et al.*, 1989).

LaCrosse (1980) hypothesised that the patient's impression of the therapist as 'expert', 'trustworthy' and 'attractive' provides the therapist with the 'social influence' to promote change. The strength of the therapist's social influence is argued to be proportional to these attributions, and directly related to the benefits the patient will gain from therapy. The more 'trustworthy', 'attractive' and 'expert' the therapist is perceived to be, the more social influence he or she will have and the greater the improvement in the patient will be (LaCrosse, 1980). The descriptive results suggest that overall, participants did consider the therapists to be 'expert', 'trustworthy' and 'attractive', as reflected in the subcategory 'therapeutic atmosphere' (within core category 'therapeutic elements').

Bordin (1976) suggests that the therapeutic alliance by itself cannot 'cure' the patient. Rather, he suggests that the technical factors (tools of a therapy) and the process factors (alliance) do not operate independently of each other. For instance, the patient's ability to

form a therapeutic attachment to the therapist is based partly on his or her assessment of the relevance and potency of interventions. This view appears to be supported by the theme 'immediate potential', where participants noted that the early promise of BFT's capacity to benefit the family was an important motivating factor in their engagement with the intervention.

3.4 Hypothesised model of the mechanisms involved in BFT

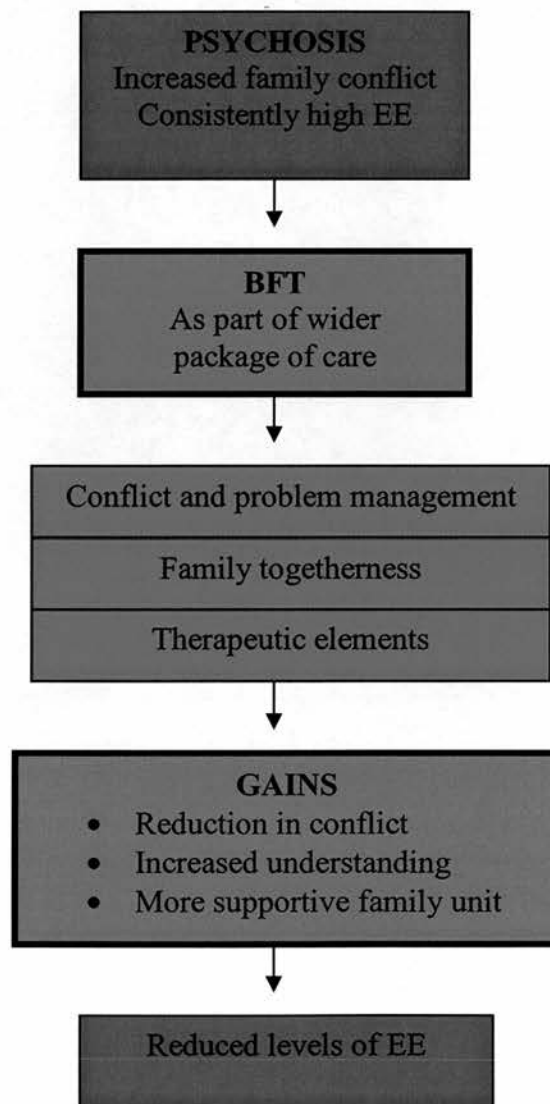
A hypothesised model of the mechanisms involved in BFT is proposed below, attempting to bring together both processes involved and outcomes drawn from the experiences of participants (see figure 6).

It is proposed that most families have fluctuating levels of EE. In families with one member who has psychosis, high levels of EE can become consistently high, leading to conflict within the family environment.

BFT is experienced within a wider package of care and this is important, as it has not been evaluated in research studies or experienced by participants in this present study as a separate or a stand-alone intervention. It is proposed that the key 'tools' of skill acquisition in BFT within 'conflict and problem management' and 'family togetherness' work alongside the process elements within 'therapeutic elements' to promote changes in family functioning.

The model proposes that the key outcomes or gains are reduced conflict, increased understanding and a more supportive family environment. These three gains combine to reduce levels of EE within the family environment, or at least to allow some change from consistently high levels of EE.

Figure 6: Hypothesised model of the mechanism involved in BFT



4. DISCUSSION

4.1 SUMMARY OF RESEARCH

BFT is a psychoeducational, largely behavioural approach in which family workers work with those experiencing psychological difficulties (key persons) and their families. It was first developed by Ian Falloon and colleagues in the 1980s and since then has yielded a large body of research providing evidence that psychoeducational family interventions in combination with standard psychiatric treatment reduces rates of relapse compared to standard treatment alone (Falloon, 2003; Dixon & Leman, 1995; Pharaoh *et al.*, 2007). However, little is known about which elements or mechanisms of family interventions are effective (Rose, 1998).

The aim the present study was to explore the experience of BFT from the perspective of those who have received it. A constructivist grounded theory methodology was chosen in an attempt to minimise the risk of forcing data into a preconceived theoretical framework and reducing the potential richness of participants' narratives. Semi-structured, open-ended interviews were conducted and analysed with 15 participants from five families.

Three core categories were generated from the data analysis: 'conflict and problem management', 'family togetherness' and 'therapeutic elements'. Further analysis allowed for the three inferred findings: firstly, the shared experience of participants, suggesting the primacy of the *family unit* as the participant in BFT; secondly, the main strategies of BFT emerging as perceived outcomes; and thirdly, the tools and processes involved in BFT.

From the results, a hypothesised model of a mechanism involved in BFT was presented, theorising the interplay between the tools of BFT (reflected in core categories ‘conflict and problem management’ and ‘family togetherness’) and process mechanisms (‘therapeutic elements’), resulting in areas of change or outcomes within BFT

4.2 IMPLICATIONS OF FINDINGS

4.2.1 Implications for theory

The results of this study cannot make direct comment on the objective effectiveness of BFT. However, results can be interpreted as providing support for BFT as a positive and useful experience perceived by participants. More specifically, the results support the notion that it is beneficial to direct the therapeutic process actively towards the entire family, rather than regarding the family as a useful tool for assisting the key person’s therapeutic development. This follows from the evidence that key persons and other family members share and influence each other’s emotional states and that adjusting the level of expression of those emotions impacts on family functioning, which may reduce the chances of relapse but is in any case also an end in itself.

Pharaoh and colleagues (1999), in a systematic review of family interventions in schizophrenia, concluded that only moderate benefits were evident from family interventions and that a large amount of ‘time and effort’ is necessary from both participants and therapist. The reviewers suggested that further evidence of potential benefits may be obtained by using outcome measures such as the subjective reports of

families. In their most recent meta-analysis, Pharaoh and colleagues (2007) again suggest the effectiveness of family interventions can be perceived with 'moderate certainty' but that high quality family services are needed for this moderate outcome and clinicians may have to make difficult decisions on treatments offered if in light of more accessible and equally effective interventions.

The findings of the present study provide support to the view that clinical practice should widen its focus as much as possible to include not only those suffering from psychotic disorder but also the people who represent both the secondary cost-bearers and often the primary environmental influence on the disorder: the family.

To focus on the families of mental health patients as a significant factor in the progress of recovery and rate of relapse, as well as the aetiology of psychosis, inevitably carries resonances of the double-bind theory (Bateson *et al.*, 1956) of schizophrenia and the anti-psychiatric tradition embraced, for instance by Laing (1961). The double-bind theory (Bateson *et al.*, 1956) proposed that schizophrenic symptoms were the result of the sufferer unwittingly attempting to fulfil two or more mutually contradictory demands made by a person highly respected or occupying a position of authority in his or her life. Symptoms were regarded as the result of the distress caused by the psychic struggle to fulfil these irreconcilable demands.

Laing (1961) extended and generalised this idea, employing it within a theory of mental illness (particularly schizophrenia). He proposed that mental illness was fundamentally a

social rather than an organic phenomenon, originating in the relationship of the sufferer to a 'family nexus' (Laing, 1965), a shared but by no means necessarily valid perception of family relations, which is created and maintained by the family and rigorously enforced on the sufferer.

Although Laing later distanced himself from his original interpretation of his theories, he has been strongly criticised for apportioning blame for mental illness to the family. Nevertheless, it may be useful to reconsider some of these ideas in the light of evidence resulting from families' experiences of BFT and the suggestion that levels of EE and other aspects of the family environment are predictors of progress in treating psychotic disorders.

However, great care must be taken that any reassessment of these controversial theories avoids criticising or stigmatising families and carers and that it concentrates on therapeutic outcomes rather than aetiological speculations.

4.2.2 Implications for practice

The findings of this study provide support for the practice of BFT in regard to participants' positive experience of receiving the intervention and the perceived improvements to family functioning. In turn, this provides support to incorporate family interventions more widely into routine practice for the management of psychosis.

In addition, training in educational and psychological strategies is needed to ensure that the efforts of key caregivers of all patients are fully integrated into clinical services at all times. Almost all patients have somebody who cares for them, or at least somebody who cares about them. With improved understanding and training in problem-solving approaches, caregivers can provide a substantial additional resource to the therapeutic team, a resource that promises to contribute to long-term clinical and social recovery from psychiatric disorders.

Participants placed a great emphasis on what has been labelled as 'therapeutic elements'. The BFT manual (Falloon *et al.*, 2004) does acknowledge the importance of engagement with families to produce the right atmosphere for skills acquisition. However, this study's findings would suggest that a greater importance should be attached to the relationship with the therapist as a process of change throughout the intervention.

This study has found that, from the perspective of the participants, the main benefits of BFT are an improvement in family relations through communication, understanding and intimacy. This encourages an understanding of BFT with a different emphasis from the intended aim of the therapy (the prevention of relapse). There is no evidence to make the inference that participants do not hope for prevention of relapse, or that BFT does not have an effect on relapse. However, the tangible benefit of BFT most recognised by its participants is improvement of family relations, and thus of patients' and carers' well-being.

The NHS can be seen as under reform designed to provide a 'patient-focused' service based on 'clinical need'. The principles of the NHS are continually developing as our understanding of healthcare changes. The principles of care for mental health have always been particularly difficult to specify within the scope of the NHS. The results of this study are relevant to a larger debate about whether the principles of the NHS should explicitly encompass general well-being. The question arises as to whether 'well-being' is part of clinical need or simply a possible side-effect, and whether improvement of patients' well-being' might strengthen the patient-focused character of the NHS.

4.3 REFLECTIVE ANALYSIS

4.3.1 Duration of interview

The majority of interviews lasted between 50 minutes and 75 minutes. Two interviews lasted one hour 30 minutes and two interviews were considerably shorter: interview 3 (35 minutes) and interview 15 (20 minutes). These variations in length were due to participants' level of engagement with the interview process or with the researcher, and to participants' personal styles of communicating in formal interviews. In the shorter interviews, participants gave a less detailed descriptive narrative about their experiences compared to those in the longer interviews.

4.3.2 Time since completing BFT

This study analysed present day narratives about past experiences and the processes involved in BFT were inferred from these narratives. Three families were interviewed soon

after completion of BFT (within three months) and two after a longer period (up to two years).

Interestingly, this variation in length of time since completion, alongside differences in the key person's stage of psychosis, did not seem to produce prominent differences in the participants' experience of BFT. All participants' narratives primarily concerned their experience of developing strategies to reduce tension and conflict and focused on changes in their relationships as a result. However, the researcher noted that families who had undertaken BFT more recently seemed to attribute slightly more of the changes to improved conflict management, whilst those who were recalling a more distant BFT experience attributed them to changes in relationships.

4.3.3 Family three interview dynamic

The two participants in family three (key person and partner) were interviewed separately by the researcher but in the other's presence, at their request. This undoubtedly changed the dynamic of these interviews. Without being able to compare these interviews with one-on-one interviews with the same participants, it is hard to know exactly how they were affected. However, both participants appeared to be no less engaged with the process or less open as the content and the details of their narratives did not seem to differ from other interviews in any pronounced way.

4.3.4 Emerging categories

The speed of the emergence or generation of categories from the narrative was unexpected. The expectation was that categories would develop gradually as the research analysis progressed. Instead, coherent themes began to emerge very early within analysis. Each new interview increased the depth and scope of the main categories.

There is a connection between the early emergence of themes and the overall level of shared experiences observed between and within families. Most participants discussed their main experiences of BFT in relation to conflict management, improved family relationships, communication, relationship with family workers and therapeutic atmosphere. Although only three families discussed the effect and understanding of psychosis, this was prominent within their narratives and thus gave justification for its development into a core category.

4.3.5 Non-inclusion of themes

Several themes emerged from the participants' narratives that were not included in core categories, for example issues around the stigma associated with mental health. The researcher felt a constant tension, particularly at the later stages of analysis, between the desire to capture the richness of individuals' experiences and the need to cluster the most significant or dominant themes related directly to the experience of BFT.

Themes relating to stigma were observed early in the data collection (interviews 1 and 2). However, this theme did not develop significantly through subsequent interviews. Although the stigma in mental health is well highlighted in the mental health literature, it did not

emerge here as a prominent theme in relation to participants' experience of BFT and therefore a decision was made not to incorporate it into a core category.

This highlights a methodological strength of constructivist grounded theory, namely that an *a priori* assumption (here, the assumption that stigma would emerge as a significant theme), which in a positivist theory would have informed the hypotheses tested, proved to be less pertinent than expected and as a result was not included in final core categories.

It is important to acknowledge that there is always the risk that the parameters by which the researcher decides how many references constitute a theme and which themes constitute a core category encode another set of *a priori* decisions, albeit probably less ideologically based ones. Despite avoiding the pitfalls of positivism, a constructionist grounded theory analysis of any significant amount of data will inevitably reduce the complexity of participants' lived experiences.

4.4 LIMITATIONS

4.4.1 Sample bias

The sampling procedure, as in Campbell's (2004) study, was reliant on the family workers who referred the participants. Not all family workers made referrals and of those who did, not all families were referred from their past caseload. The reasons for this were not investigated formally. Aside from the inclusion and exclusion criteria, other factors might have biased the sampling, such as a reluctance of family workers to refer families that they

perceived would not engage in the study or that they perceived as not having benefited from the intervention. In an attempt to minimize this potential bias, family workers were encouraged to refer families regardless of perceived intervention outcome and assured of the anonymity of the families and family workers in the presentation of the research.

The recruiting procedures limited the study to participants who had completed a full course in BFT. From this, it can be assumed that completing BFT implies a reasonable level of engagement with the therapy and therefore families that agreed to participate in this study were more likely to have engaged with BFT. Using this recruitment procedure meant that families which were unable to engage or families that decided to drop out of BFT would not be referred and therefore their potentially different and potentially more negative experiences could not be explored. The results of this study should be understood as applying within the context of families which were able to engage, participate and complete a BFT intervention.

The key person from family 5 decided to withdraw from the study on the day of the interview. This was after three members of the family had completed their interviews. The reasons for the key person's decision were not investigated, as the research procedure stressed that any participant was free to withdraw from the study without needing to provide a reason. During the design of the study this potential scenario was identified and the decision was made to include participants from a family if two or more family members completed the interviews. Although the key person's experiences of BFT are undoubtedly very important, the inclusion criteria were chosen to reflect the study's intention to

investigate individual experiences within a family and not only experience of the family and key person as a group.

4.4.2 Interview procedure

The use of one interview per participant can be viewed as a limitation, in that it can produce a more superficial view of what is being investigated (Charmaz, 2003). Charmaz suggests that conducting by conducting one interview per participant this limits the narrative produced as participants are more likely to 'clean up' the description of their experiences in their first discussion with the researcher. It is clear that participants' narratives of their experiences might alter through time and a single interview is not able to capture this process. Multiple interviews might have added to the richness of participants' narratives and given participants the opportunity to become accustomed with interview procedures, which may have increased their level of reflection. Multiple interviews might also have allowed the researcher the time to explore emerging themes, possible misinterpretations of experiences and areas of particular interest to participants in greater depth.

However, the requirement of multiple interviews over time is a large demand on participants and was not viable within the time-scale of this thesis. A factor that served to counteract the constrictive aspect of single interviews was the difference in length of time between completion of BFT and families' participation in this study. Although this could not take into account the possibility that individuals' narratives may change over time, it allowed the research to explore how different narratives may differ according to time

elapsed since completion of BFT. In fact, however, the analysis suggested no major difference.

A criticism of the interview questions chosen is that they concerned the general experience of having received BFT, rather than solely the participants' experience of BFT sessions. This wider scope of questioning at times generated narratives that focused on more general experiences not directly linked to BFT, such as the impact of onset of illness on families, and that therefore could not be included in analysis. However, this range of questioning also allowed for the development of narratives that included experiences of changes within the family dynamics before and after BFT, allowing participants to reflect on the impact they felt BFT had on them personally and in terms of family functioning.

4.4.3 Analysis

Grounded theory analysis requires coding and analysis of each transcript before further data collection. Time limitations and the logistics of conducting interviews at convenient times for participants meant that the length of time between different interviews varied from two interviews conducted on the same day (e.g. key person and mother from family 1; mother and father from family 5) to interviews spread over several weeks. Although not ideal, this factor was not deemed to make a significant impact on analysis.

Ensuring credibility of findings is given importance in grounded theory (Denzin & Lincoln, 2002; Schwandt, 1997). One method of establishing credibility is to present the research findings to the participants and to evaluate the extent to which the researcher's interpretation of the narratives fits with the participants' perspectives. This step was not followed in this study, again due to time limitations. Instead, this study used 'member checks' and 'triangulation' of techniques (Janesick, 2002) in regard to developing interview questions from emerging themes as interviews progressed. This allowed exploration into the researcher's interpretation of emerging themes with participants in later stages of interviews.

4.4.4 Hypothesised model of the mechanism in BFT

The hypothesised model of the mechanisms involved in BFT was developed from the researcher's interpretation of the core categories generated from analysis, as well as from the literature on BFT and the constructs of EE. Within the hypothesised model it was proposed that there was an interplay between the core categories 'conflict and problem management', 'family togetherness' and 'therapeutic elements' that resulted in the outcomes of reduction in conflict, increased understanding and more supportive family unit. However, the model does not provide insight into the strength or causal links of the relationships between the categories

4.4.5 Generalisability

By their nature, qualitative investigations use much smaller samples than quantitative investigations, meaning that findings cannot (unlike quantitative findings) be generalised to

wider populations. The ability to generalise outcomes is not the intended aim of grounded theory rather, its focus is on capturing the specificity of unique individual experiences. The findings of this study should be understood within the context of the situations of the participants and the researcher. Constructivist grounded theory emphasises the researcher's active role within data collection and analysis. The researcher's role within this present study and her interpretations of findings should be understood in this context. From this, the reader can make his or her own judgment on the generalisability of findings to other similar groups within similar contextual backgrounds.

4.5 FINAL THOUGHT

The phrase "*held up against each other*" which appears in the title of this thesis is a quotation from one of the key persons interviewed. The researcher felt it captured powerfully the ambivalent attitudes held by family members about their relationships, in that it expressed the conflict and tension within families, while implicitly invoking their powerful emotional bonds and the responsibility for mutual support.

It's become a lot less confrontational and I feel more kindness coming from my sister now so I think, that was one of the ways I think...because we were all really held up against each other as human beings.

Key person, family 1

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6. APPENDIXES

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Appendix I

Family referral form

Family Referral Form

for participation in

Understanding Families' experiences of receiving Structured Family Work

Your Details

Name:.....

Email:.....

Department:.....

Telephone:.....

Family Details

Name of key person: 1).....
Diagnosis
.....

Name of other family members: 1).....
(who received BFT) **and relationship to** 2).....
key person (e.g mum, sister) 3).....
4).....
5).....

When did the family receive BFT?.....
(month(s)/year)

How many sessions were conducted?.....

Where were sessions held? Home ☐ Other.....

Are any family members under 18 year old? Yes ☐ No ☐

Family Tel:.....

Family Address:.....

.....

.....

.....

Are you still in contact with the family? Yes ☐ No ☐

Do you think the family would prefer to be contacted by you initially (by phone) to ask if it's ok to send them an information sheet?

Yes ☐

No ☐

Many thanks for this potential referral for this study. Please return via:

Email: [REDACTED]

Or by mail: Alina Galis
Trainee Clinical Psychologist
Department of Clinical Psychology

[REDACTED]

Tel: [REDACTED]
Mob: [REDACTED]

Please feel free to contact me if you require any further information about the study or would like to discuss possible family referrals.

Many thanks

Appendix II

Information Sheet

Understanding Families' experiences of receiving Structured Family Work

I would like to invite you and your family to take part in a research project. Before you decide if you want to take part it is important to understand why the research is being done and what it will involve. Please take time to read the following information sheet and discuss it with others if you wish. You are also welcome to contact me if anything is not clear or if you would like any further information. There is no hurry to decide. My contact details are at the end.

Thank you for taking the time to read this.

WHAT IS THIS RESEACH STUDY ABOUT?

I am currently carrying out some research looking at Structured Family Work. I am particularly interested in families' experiences of doing this work, the effects both positive and negative. I aim to do this by interviewing all family members to gain information about their experiences.

WHY HAVE I BEEN ASKED TO TAKE PART?

You have been invited to take part as you and your family have received Structured Family Work in [REDACTED]

DO I HAVE TO TAKE PART?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form (of which you will get a copy). If you decide to take part you are still free to withdraw at any time and you do not have to give a reason. A decision to withdraw or a decision not to take part will not affect any future treatment you or your family receive.

WHAT WILL I BE ASKED TO DO?

Once I know that you are interested to take part, I will contact you to arrange a time to meet. I would like to interview each family member separately to get everyone's views and opinions and the interviews will last between 25-40 minutes. The interviews can be organised at dates and times most suitable to you. They do not have to happen on the same day. Interviews can take place either in your local health centre or in your home, which ever suits you best.

With your permission I would like to audio tape the interviews so that I don't forget anything that is said. I will then transcribe the tapes onto computer for analysis of the main themes discussed. During the interviews I will ask you to talk about how you felt about Structured Family Work. The sort of questions I will ask are: "Can you tell me what it was like for you doing this family work?" "Were there any benefits or negative bits about the work?" "Do you think it has changed the family relationships".

ARE THERE ANY RISKS OR BENEFITS TO TAKING PART?

Although you have finished your Structured Family Work, I hope that this study will benefit you by providing you with the opportunity to have your views heard. Your opinions may help us to further develop the services that families like yours will receive in the future. You do not have to share any information you do not wish to so there should be no risks associated with taking part. However you may stop the interviews at any time if you begin to feel upset or distressed. You will also have the opportunity to discuss any potentially distressing feelings that might arise as a result of the interviews with a Clinical Psychologist, confidentially and

independently of me. During the interviews if anything illegal or unethical issue is raised about your experience of Structured Family Work, the appropriate complaints procedure will be discussed.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

All information collected during the course of this study will be kept strictly confidential. I will give the transcript of your interviews code numbers and remove all identifiable personal information's e.g. names and places. The only people who will have access to the information during the study will be myself and my research supervisors. All information you provide me will be stored in a secure location (i.e. a locked filing cabinet). At the end of the study the audio tapes and transcripts will be erased.

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY?

In order that other professionals can learn from the findings of this study, some articles and papers will be published. However your names will not be used and you will not be able to be identified in any publication from this study.

WHO IS ORGANISING AND FUNDING THE RESEARCH STUDY?

The research is being carried out as part of the academic requirement for a Doctorate in Clinical Psychology, University of Edinburgh & East of Scotland NHS Clinical Psychology Training Course. It is being hosted by NHS [REDACTED].

WHAT IF SOMETHING GOES WRONG?

The University of Edinburgh has approved this research and is acting as the sponsor. It will therefore provide indemnity and/or compensation should you incur any non-negligent suffering as a consequence of taking part in the study.

WHO HAS REVIEWED THE STUDY?

The [REDACTED] Research and Ethics Committee, which is responsible for scrutinising all proposals for research in [REDACTED] has examined the proposal and raised no objections from the point of view of medical ethics.

CONTACT INFORMATION

If you would like more information or have any questions about the research, please feel free to contact me.

Alina Galis, Trainee Clinical Psychologist

Telephone:

[REDACTED]

Email:

[REDACTED]

By post:

Psychology Department
[REDACTED]

THANK YOU AGAIN FOR TAKING THE TIME TO READ THIS.

Appendix III

Cover letter

Primary & Community Division
Department of Clinical Psychology

[REDACTED] Hospital
Tel: [REDACTED]
Fax: [REDACTED]

N 3
[REDACTED]

Date 2007

Dear,

I have been given your address by....., your family worker, as he/she thought that the research study I'm working on might be of interest to you and your family.

I am a Trainee Clinical Psychologist working in the [REDACTED] Clinical Psychology Department and I am currently working on a research study as part of my training. The study aims to gain a deeper understanding of families' personal experiences of receiving Structured Family Work.

I have enclosed an information sheet explaining what the study is about and what it would involve if you choose to take part.

..... thought that you would not mind me calling you in the next week to tell you a little more about the study and discuss whether you might be interested. This will not mean you are under any obligation to take part in the study.

Thank you in advance for taking the time to read this.
I look forward to speaking with you.

Yours Sincerely,

Alina Galis
Trainee Clinical Psychologist

Dr [REDACTED]
Chartered Clinical Psychologist (Supervisor)

Headquarters
[REDACTED]

Chairman [REDACTED]
Chief Executive [REDACTED]

Appendix IV

Interview questions schedule

Interview Questions Schedule

Interview questions were developed from the main and supplementary research questions under investigation:

Main research question

1. What is the lived experience of individuals within families that have received BFT?

Supplementary research questions

1. Do families perceive that there has been a change as a result of BFT?
2. What are the processes involved in change?
3. What are the effective elements of BFT as perceived by participants?

A flexible interview schedule was used during the interview process with the aim of encouraging participants to openly describe their experience of having received BFT. The researcher aimed to use open ended questions and supplementary questions to gain clarity and details into what participants discussed. Table 1 illustrates the interview schedule at the start of the interview process.

Table 1: Interview schedule at the start of interview process

Interview schedule: beginning of interview process
How did you and your family become involved in the family work?
What was your experiences of the family work?
What did you discuss during the family work?
What impact do you think the family work had on you and your family?
Do you think the family work led to any changes in the family?
What do you think lead to the changes?
Did you find any parts of BFT particularly helpful or unhelpful?

Interview questions developed throughout the interview process as analysis of narratives generated emerging themes. Table 2 presents the interview schedule at the middle of data collection and table 3 presents the interview schedule at the end stage of the interview process. New questions introduced in the interview schedules are highlighted in italic text.

Table 2: Interview schedule at the middle phase of interview process

Interview schedule – Middle phase of interviews
<p>How did you and your family become involved in the family work?</p> <p>What was your experiences of the family work?</p> <p>What did you discuss during the family work?</p> <p><i>What was the atmosphere of the family work?</i></p> <p><i>Can you described the relationship you had with your family worker?</i></p> <p><i>What was your experience of the 'structured family meetings'?</i></p> <p><i>What impact did the 'structured family meetings' have?</i></p> <p>What impact do you think the family work had on you and your family?</p> <p>Do you think the family work led to any changes in the family?</p> <p>What do you think lead to the changes?</p> <p><i>Do you think the family work made any changes/had an effect on:</i></p> <ul style="list-style-type: none"> ▪ <i>Family tensions/agreements?</i> ▪ <i>Understanding of psychosis?</i> <p><i>What do you think lead to these changes?</i></p> <p>Did you find any parts of BFT helpful or unhelpful?</p>

Table 3: Interview schedule at the end phase of interview process

Interview schedule: end phase of interviews
How did you and your family become involved in the family work?
What was your experiences of the family work?
What did you discuss during the family work?
What was the atmosphere of the family work?
Can you described the relationship you had with your family worker?
<i>Can you describe the atmosphere of the family work?</i>
What was your experience of the ‘structured family meetings’?
What impact did the ‘structured family meetings’ have?
What impact do you think the family work had on you and your family?
Do you think the family work led to any changes in the family?
What do you think lead to the changes?
<i>Do you think the family work made any changes/had an effect on you or your family in relation to:</i>
<ul style="list-style-type: none">▪ <i>Family relationships?</i>▪ <i>Family tensions/agreements?</i>▪ <i>Communication styles?</i>▪ <i>Family support/closeness</i>▪ <i>Understanding of psychosis?</i>
What do you think lead to these changes?
Did you find any parts of BFT helpful or unhelpful?

Introductory interview questions

At the start of each interview the researcher’s opening statement aimed to invite participants to speak about their experience without predefining any topics for discussion. For several participants this style of starting interviews appeared too wide and a prompt question regarding how they became involved in BFT was asked for example:

(researcher): So really I would like to leave it as open as possible, I haven't got a list of questions as such I just really want to gain your experiences and memories about the family work you did.

(key person): Oh right...

(researcher): What it was like for you and firstly how it came about?

Key person, Interview 1

At later stages of the interview process the researcher introduced that she had some specific questions related to how previous participants had described their experience of having received BFT. However, the researcher continued to begin interviews with an open statement about the participant's personal experience for example:

So as I was saying, this interview is so I can try to understand your experience of the family work you did. I have a few questions but first I would like to just open it up to you to talk about your experience.

Researcher, Interview 13

Supplementary questions

The interview schedule was used flexibly to allow participants to lead discussion based on their personal experiences. Therefore participants were not all asked the same questions, instead the researcher tailored her questions for each interview. As suggested in Charmaz (2006) guide to grounded theory interviews, participants did most of the talking and the researcher aimed to listen sensitively to participants' narratives and encourage them to continue. After a main question (set out in the interview schedule) was asked, the researcher asked supplementary questions based on each participant's responses.

Supplementary questions aimed to encourage participants to provide details to their responses, clarify what was being said and question whether their experiences of changes was perceived to be directly linked to their involvement in BFT. Below are two examples

of longer extracts of transcripts that illustrate supplementary questions used during interviews.

Example 1: Extract from interview 1 with key person (family 1)

(key person): I can't remember and we decided to continue with or start the sessions at home with my sister, because she was working in [place] at the time and would be travelling to [place] because she lives in [place]. So my sister came round and [family worker] came round. And I'd have to say that it was a positive experience, because we'd had in the past when I was ill and wasn't on medication I think me and my sister, I think I caused her to move out originally. And she's going to move back again because of my medication and things are very tickety boo, I've managed to keep things down to a level and not let myself be affected the illness and how it makes me more hostile to people. That's really what I've picked up as to what happens when I'm not on medication and that really... So things look like they are going to improve in the future and my sister coming home is going to help her out because she's been in a bit of difficulty at the moment. So things are going to be better. But I think the family intervention did help with that because it helped highlight that I do suffer from this illness and it does affect my thinking and it does make me, change me in a way from the norm as it were, and that, that brought to the attention by the family, by my mum and by my sister during the sessions, I think it helped me to understand that there're human beings as well and that we have to get on together and it's been positive in that way. Yeh there were various things that I thought that I've incorporated into how I actually behave towards my mother now to do with, I think it's the making eye contact and then thanking each other for the things that we do for each other. Like she made soup today so I thanked her for the soup, if I can remember, did I? But I found that's generally been more incorporated in to the... more considerate of the efforts which she goes to, to help.

(researcher): And do you think that came from the sessions you did together?

(key person): Yes that definitely helped me in that way and helped my mum in that way, I think and yeh and trying to make things nicer at home and kind of like get over the illness, how it affects me and basically get back to an easier way of dealing with things. If there's any issues that come up, I'm sure that the actual sessions possibly helped my sister.

(researcher): So it's something about, you described something about it helped you see that your mum and your sister were also people, and helped you change your behaviour and it helped her as well.

(key person): Yes I think so. I'm pretty sure that it has. It's brought her in to the involvement with.... because before it was really just my mum looking after me and caring for me and helping me along with issues with the illness which are you know social

isolation and lack of work. And now I feel more encouraged to do things by my mum which is good and she isn't banging a stick on the ground saying get yourself out and find a job kind of thing, which is what I want to do eventually but more on my own terms because I've been to college and I've worked down in [place] as well. She's helped me to see that I can maybe get back to that. But now that [sister] been involved with these sessions she seems to be more aware that I'm struggling to do things like that. And that um...a kind word here and there can help me to keep at those things. Where as getting negative criticisms, getting negative attention can really turn me off, basically.

Example 2: Extract from interview 13 with a father (family 5)

(researcher): What was it like doing the family work?

(father): You know the most important thing I saw with the family work, I mean it was like basic, if you look back on it now, it was really basic but it was also a very, very important thing, which maybe we never came to us before. I wasn't brought up like that...so before we get anything done in the house, it would be a situation where I would say just '[key person] do this,' '[younger son] you do that', you understand me. There was never like a collective family meeting, she{the family worker} brought that concept of us meeting as a family to share thoughts on what we are going to do and then the decision is like participatory, so everyone feels committed and there's this focus, I mean every person, by the time we participate you see the problems actually, that they have also contributed so they feel committed, so like the situation where I maybe said '[key person],you do this' and '[younger son],you do that', there was no general happiness because they did not contribute to it and they're really not committed to getting things done. That was the first things. And there was also this, expressing pleasant and unpleasant feelings and how to just generally cope with different situations, it would look basic to some other people but it was not something maybe that I was brought up with, to sit down with them {the children}, every one week or two weeks to have a family meeting and sit down and discuss things, analysis things and get it sort. So those were the things.

(researcher): So what effects do you think the meetings had?

(father): I saw the benefits, immediately I saw the benefits. I knew that it was something. Because it was something that was giving us problems in the house, and immediately it improved the atmosphere in the house, it improved my relationship with my wife and my kids so it was something that...and we looked forward to [family worker] coming around also. Because we looked forward to [family worker] coming to the house to meet each other to you know to at least have maybe another thought in what is going on for us, I mean, it made things easier for us and given that it was a very difficult period in terms of [key person's] illness and everything, it made things easier for us.

(researcher): How do you think that [key person] found it?

(father): It was useful for him, because I mean umm, the point with the family meeting is that maybe, lets assume that it was a task that was being assigned and it was being assigned to [key person] who is, I put it in brackets 'ill', and maybe I thought he could perform that task but somebody else could point it out, maybe the little one could point it out and say 'look, in view of this and in view of that it, would be unfair and unwise us to expect [key person] to perform that task', and it would be maybe something I would have overlooked, you get what I'm saying, because I would just say [key person] you do that, and at the end of the day maybe it's not done and then the strife, the blame would have been between me and [key person] and [key person] would also not feel practically good with himself because he would now have achieved the goal that was set out for him, because it was just past down, the authority was just pasted down. But now the discusses take place and other people may have notice what the problem is, maybe because of [key person's] health or what he could achieve in the end, so that was what...I'm sure [key person] found the sessions useful. Particularly the {structured} family meeting was very good, because it was a forum where we could air our view and do different things and then plan on what to do so...So it was something that I think was useful to [key person] and useful to us.

(researcher): A lot of people have said that was the {structured} family meetings were a key aspect.

(father): Yeah, yeah, there were different bits I said, expressing difficult feelings or expressing good feelings, those were things you just overlook, so different things, it was nice anyway. And [family worker] also coming around, it was something we looked forward to.

(researcher): You got on well with [family worker]. Do you think that was important?

(father): Yes, it is very important for another person to come and bring you skills of how to live or how things should be done and not just you, you can't be a fountain of knowledge of all things. And now our situation, if we have a major problem in the house and when I say problem I mean major decision to be taken, we know immediately that there is a need for a {structured} family meeting. It's not just a decision I will go and make in my room and then come down pass it down, if there is a major decision we find the kids, or I will immediately say I think we need a family meeting for that, you know. It is something that we know for immediate decisions it not that someone should take the decisions myself, because the way it was before I would just make the decisions and possibly I would consult the wife and say this is what I'm thinking about and she would maybe try to persuade me one way or another and then we would just go ahead and implement it. There was a lot of strife under that situation. An now we just sit down for maybe 30 minutes and people air their views, at that point in time, when I air my views it will be apparent to everyone what the defects are and which we can then correct and a proper decision is made.

Relevance of material versus engagement

Due to the more open-ended nature of the interviews as compared to a clinical interview, there were sections in some interviews where participants discussed topics that were not directly related to the experience of having received BFT. The researcher felt that it was important to allow participants to talk freely to aid engagement with the interview process.

However during analysis the sections of narrative that were not related to BFT did not develop into themes of the experience of BFT. For example in the extract below the participant spent several minutes describing their career aspirations. This part of the interview was not related to their experience of BFT however the researcher felt it important to listen to the participant before re-focusing the discussion back to BFT.

(researcher): Yes, house work is difficult for all of us. It sounds like there's something about going through this work has helped you learn a bit about yourself?

(key person): Yeah, well I realised that the place would just get in a tip if I don't help out. It's not good to be relying on my mum for that kind of thing. Because I'm usually reasonable tidy, when I had my own place I kept that reasonable tidy, possibly just once a month or that. And had a lot of stuff as well, my [work desk] and my [work papers] and stuff and I managed to keep that all neat and tidy and put it away and things. Because my minds always on, well a lot on [professional work].

(researcher): Is that your field?

(key person): That's where I have most experience working and I know that I want to achieve things within that field as well. I want to develop, I want to make this [project], and I want to develop a [big project], but in a [different] form.

(researcher): Humm, Interesting.

(key person): Yeh, that kind of, yeh it's a lot of hard work and at the moment I'm not capable of that. It's like a dream for me. I did at [place] college, I did a two minute [project] of like an advert advertising [a product] which was the [names] characters eating some [product] and changing back into [names]. So it's like a nice little idea that has changed into ... I've started, I've [a new project], I've done ten pages of [the new project]

as it were for about... I've also written other [projects] and I want to develop these [projects]. Getting into working again, and thinking along the lines of creating [projects], showing ... it's big steps for me, it's a big ambition, I don't know if I'll ever achieve it but I will try. I need to work more consistently as in every day, but sometimes I don't feel so great. It's a physical feeling thing and also the medication makes it difficult for me to exercise and things. So that's where I'm at the moment.

(researcher): Going back to the family work, about but what it was like for you? What was it like to sit down with the family and [family worker]?

Family 1, key person

Appendix V

Transcript notations

Transcript Notations

Below is a guide of the transcript notations used in the transcription of participants' interviews. All interviews were transcribed *verbatim* including incorrect grammar and colloquial language. Transcript 2 (mother, family 1) has been used to illustrate notations used.

Block quotations

All block quotations of transcripts were presented in *italics* and were single spaced throughout the thesis, for example:

But what's happened now is that we, as a family, have become able to be more and more a family. The family sessions really helped with that, I mean, that's part of it, but it's not like cause and effect. The medications that [key son] has been on, he's chosen the last one himself and that's made a tremendously big difference.

Family 1, mother

Square brackets

Square brackets ('[]') notation were used to indicate when identifiable information such as names, places or potentially identifiable information were replaced with anonymous names, for example:

[key person], [family worker]

[local health centre], [cafe], [work project]

Rounded Brackets and colon

Where quotations from transcripts included speech from both the participant and researcher rounded brackets followed by a colon ('():') notation was used at the beginning of the section to indicate who was speaking, for example:

(mother): I suppose and again because of my nursing background, I tend to smother a bit and overprotect. And I had to challenge myself about that a lot and say to myself 'I don't know so much', because I'm much more relaxed then I was. And again I think that the family work that we did has enabled me to be a bit more relaxed than I was, as well.

(researcher): Is that something you noticed about yourself before the family therapy?"

(mother): I don't, I was internally aware before. I may have been up here {in my head} but not in here [in my heart]. You know, not... I may have...it may have been tokenism but not real.

Family 1, mother

Three dots

Three dots notation ('...') was used to indicate an untimed pause in speech, for example:

You know, not... I may have...it may have been tokenism but not real.

Family 1, mother

Three dots in rounded brackets

Three dots in rounded brackets ('(...)') notation was used at the beginning or end of a section of narrative to indicate that the section presented in the quotation was not the full sentence within the narrative, for example:

(...) because I'm much more relaxed then I was. And again I think that the family work that we did has enabled me to be a bit more relaxed than I was, as well.

Family 1, mother

Braces

Braces ('{ }') notation was used to indicate significant non verbal communication or used when supplementary information had been added, which was deemed by the researcher as necessary for understanding the quotation presented, for example:

I don't, I was internally aware before. I may have been up here {points to head} but not in here {points to heart}. You know not... I may have...it may have been tokenism but not real.

Family 1, mother

But the comforting thing about it {BFT} was that you were not in control of it, [family worker] was in control of it. And he took that responsibility and that commitment to enable the emotions to be allowed and that, to have that safety for that to happen enables learning, in my opinion, learning to move forward. It's like a captain of a ship, they take the responsibility and you're able to get on with something that if that person wasn't there you won't be able to do, kind of thing.

Family 1, mother

Appendix VI

Extract of transcript (interview 6) with initial coding (NVivo)

Father (Family 2) Interview 6

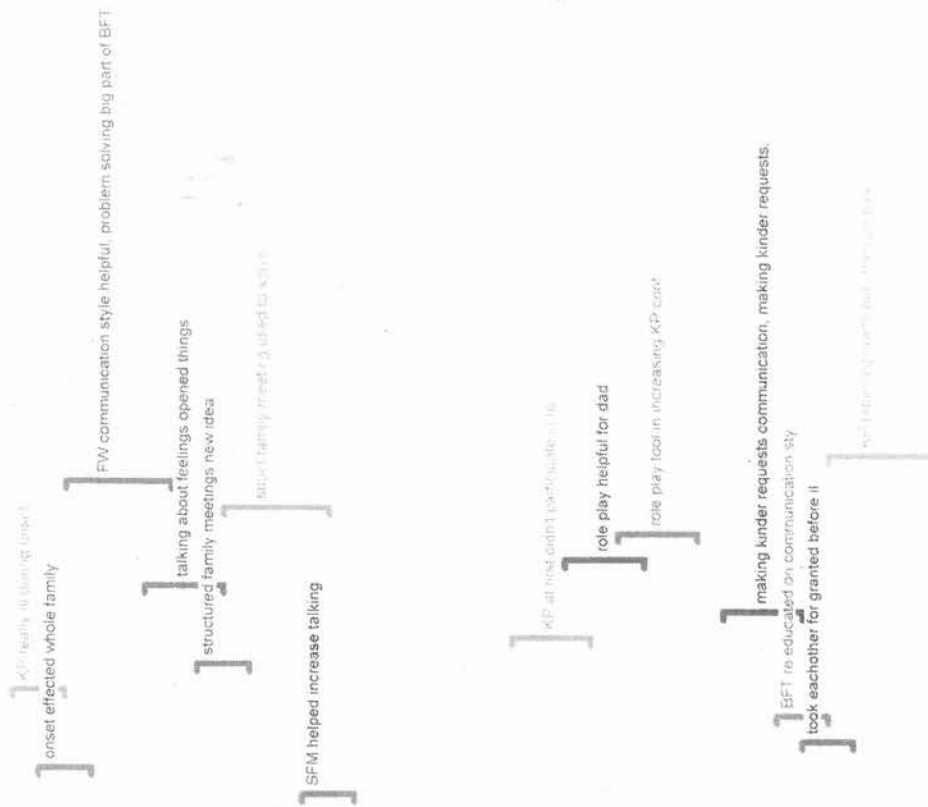
(researcher): Ok, well thank you. Some general themes are coming out from other people I've interviewed about what their experience of the family work but I'd like to start by asking you about your views and impressions of the family work, what the experience was like for you?

(father): Because [key person] was really ill when she was first diagnosed with the problems she had...it took a lot out of the whole family, my wife myself and [key person] obviously. And then once we got through that part of it, and umm [family worker] kinda came on board, it was really helpful the way she put things over to us for instants...problem solving, that really was a big part of it for us. To sit down and actually to talk through what we were feeling to each other and it's you know, it opened things up so, and having family meetings which we would never probably do before. If there was a problem we got in the mode of saying 'right, lets have a family meeting' and we'd sit down and everyone would say their view of what was going on or what should be going on and solving problems. Things like that really helped us and allowed us to talk to each other.

(researcher): Do you think it was the sitting down and talking things through openly?

(father): Yeah, when [family worker] first came on board she had some role play which [key person] didn't really get involved in because she was very shy, very quiet and obviously still quite ill so myself and [wife] sort of took the role parts and played the parts in it and I thought that was pretty helpful and it started bringing [key person] out of herself a wee bit and umm and since then she's come on leaps and bounds and as the weeks went on with [family worker] there was a different because we were talking to each other and you know and it was the way [family worker] put it over, it was the way we asked each other not the sort of 'you do the dishes, you do this' it was 'would you do it please' or 'can you do this'. And it was the way it probably re-educated us to the way we actually spoke to each other was really helpful. We probably took each other for granted before plus the fact that [key person] was away from home for about four years, so myself and [wife] were alone for all that time and then we get our child back...ill, so that is, it put a lot of strain on us.

(researcher): So can we look back at that time before the family work and at the beginning of the family work sessions, you said earlier that it helped the family talk about their feelings...



father): Yeah, it was like we were walking on egg shells round [key person], obviously we didn't realise she was unwell because she didn't stay with us, she stayed with her boyfriend. And I think at that time, looking back hind sights a great thing, but looking back [key person] sed to phone her mum up and after the phone call [wife] would be in ears because they'd be arguing over the phone, but we thought it was must one of these things, still not realising there was a problem. And hen, they used to come up now and again, and I actually spoke to her oyfriend and he told us that she was on some tablets for depression, we didn't realise this of course, and then all that with the boyfriend and er split, they broke up and on top of the illness the heart break on top it all, it was really, really hard. As I say it was like walking on egg shells around each because at that time my wife, she was eeling pretty bad, so you know she was getting ill with it, so I was rrying to look after two women and it sort of ...you know.

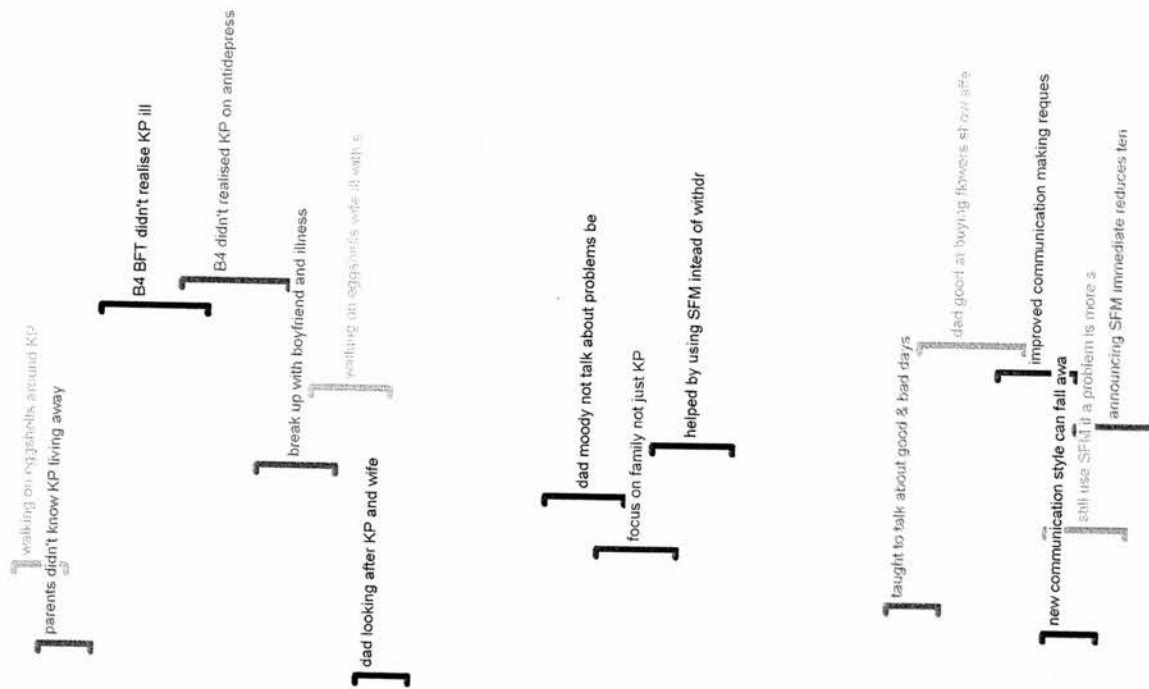
(researcher): And how did that effect you?

father): In a sense, but I'm a pretty moody person and if things weren't bing well I would go in a huff and I would sit and wouldn't talk or anything like that, and it helped me probably in that sense because then ter our sessions it wasn't all about [key person] being ill it was out the family and probably helped me because then instead of...it was ets have a family meeting', so it always reverted back to lets have a mily meeting. And we still do it.

(researcher): So having the family meetings was a way to dealing with problems or difficult emotions?

father): Yes, we were taught to talk, talk to each other and express to ch other the good days, bad days, love, a bunch of flowers is not only r...I must admit I do that often anyway. I mean last week when [wife] t the mums I took a bunch of flowers, but I've always been that type, t only because I've done something wrong {laugh}. I think over the st year we've communicated better to each other, it's not 'do that, do at, it's 'will you do that, can you do that'. It does sort of fall a y a bit but if it gets to a more serious mode then we would say 'oh, mily meeting' and just chuckle about it, because we realise yeah it's ing wrong, lets get it sorted and lets talk.

(researcher): Do you think it helps highlight when things are going ong? All families have arguments...but by saying lets have a family eting...



father): We realised we were doing it wrong before and it's so important to talk to each other. Sorry can I get you a tea or coffee?

researcher): Oh, no thanks I'm fine

father): You sure?

researcher): Yes, no I'm fine, thank you.

father): I think the sessions really helped and the problem solving was easy because [family worker] used to sit back and say 'right talk to each other, let's have a chat'. And we would start talking to each other and we would interrupt and say 'you've just brought another problem in to the problem you had, you've not solved the first one' so when you stopped and thought about it... yeah, your right'.

it was a good learning curve, it was like being back at school again the right manner because the way you are in life you think 'I've done it all that anyway' but she brought us sort of back down to a level, think about what you're saying, don't bring other problems in until you've actually solved the first problem.

researcher): And what effect did that have?

father): I think it had the effect of, we realised that umm, if you solved the problem within the three of us, because that's what we were talking about, the three of us, it was a lot easier as long as it was thought about how we were going to solve the problem and not add more problems or pressure on to what we were trying to solve. And again it made us talk more, because then we were realising that we were trying to solve a problem but bring a problem in before we solved the first problem. So what we used to do is have a family meeting and sit down and everyone had a say. What we'd done today and how we feel today, do you have any problems with what happened today, you know, [key person] would have a wee chat, [wife] would have a wee chat and then I would have a wee chat. So it... it helped, because we tried to get... and even [key person] was in the mode 'remember mum has got to have her leisure time, we'll go away down the shops, let's leave her for two hours'. So she can read a book or sit in the garden or sit here, no TV, nothing distracting her, you know calm down and have her own space for a couple of hours.

] realised not talking b4 was wrong st

] problem solving in sessions key
] FW encouraged talking to each other
] FW helped identify unhelpful prob so

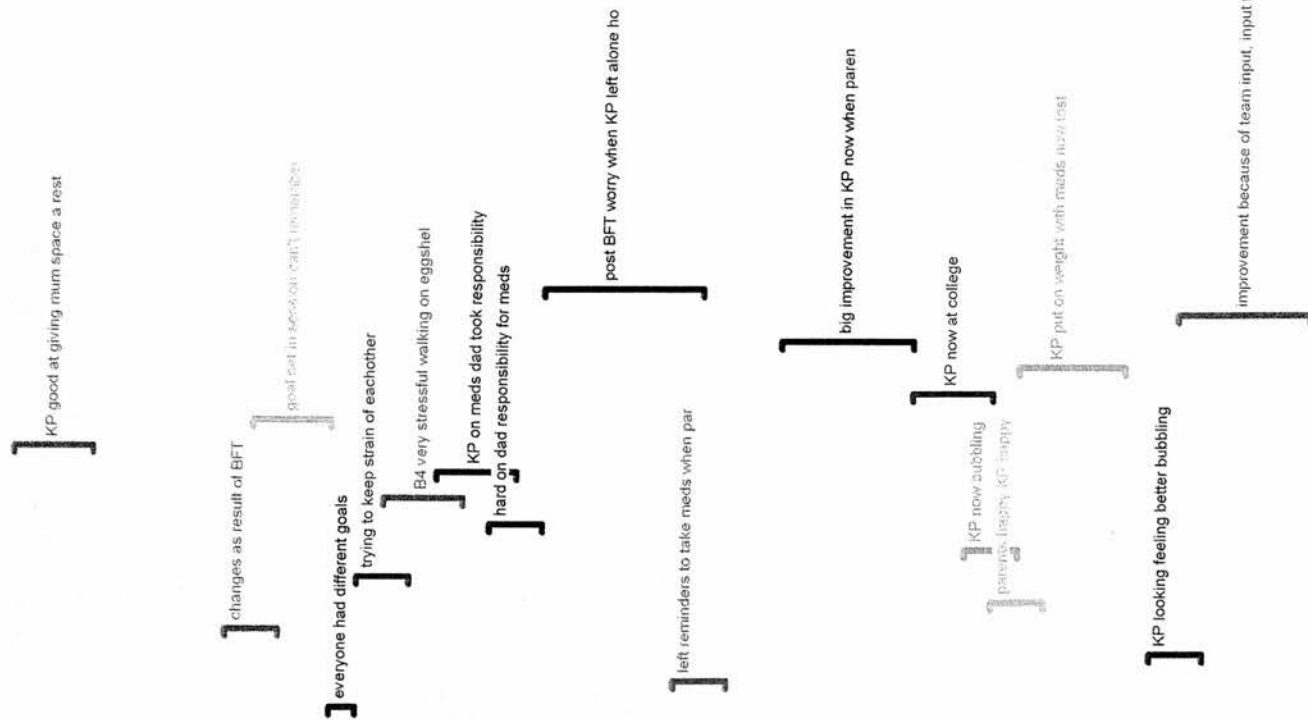
] back at school breaking old styles
] prob solving not adding more probs

] realised problem solving with whole
] not adding more probs in when prob s
] talking identified bringing in more
] prob solving in SFM everyone inputed
] SFM sharing as experiences with I
] hp being considerate of MUM

and I think [key person] was pretty good with that, she used to say that, you know she used to say 'lets give mum her own space, lets go away and have a run in the car'.

researcher): Do you think that was a change because of the family work?

father): Umm, yeah it was, again it was all brought in because we were doing this family work, we were told have goals, you must have your goals. I can't remember what my goal was, I think I wanted to perfect a one or something so, I love being in the kitchen, cooking and things like that. We all had different things we were trying to do. To loose weight was one of mine, very difficult you know. It was things like that and trying to keep the strain of each other as such. Because at a point it was very, very stressful and as I say we were walking on eggshells round about how we were going to deal with things and [key person] was on some tables on some medication and I had to make sure she was taking that medication. So it was really hard on myself to make sure she did that medication. I mean, I was happy to make sure, because I knew there was there for her to take. The only time the worry came in was when we went on holiday, it was January I think. I sent [wife] and [key person] to [holiday home], [wife] went for two weeks, [key person] went for the first week and then I went for the second week and [key person] home. And the worry then was medication so I made sure my oldest daughter and my son would call in and make sure she was ok And I had stated notes everywhere you know 'remember the tabs' 'remember this and that' and we phoned every day. And probably at that time and hind sight again, it was probably too early for us to go on our own on holiday because she wasn't well enough. So it was umm, and that was a year past January so this January again we went away for two weeks, [key person] went for a week then I went for week, and she was fine when we got back. There's been a real progression and two weeks ago myself and the wife went for a week in [holiday home] she was on her own and she was fine. I think she was glad, to give her a bit of space. She's got her place back college, she's working really hard and hopefully she's going into her second year. She's absolutely bubbling, she's going about singing in the morning. The different is absolutely remarkable, we happier because we're happy. You know when she first went on the medication she sort of ballooned up and umm all her clothes went into the attic, she was a size 10 or 10, she went up a few sizes and now all the clothes are back out of the attic and she's started wearing her 8 to 10s again. And it's not a worry but we keep saying to her she looks fine the way she is, she doesn't need to loose more. She looks fine, she's just looking so much better and feeling so much better and bubbling, she's bubbling. And really all because of the help we've had from the team, because it was a team effort right through from [CPN], the psychologist girl, I think she's left now. She looked after [key person] brilliantly, and the doctors and [family worker] they're all been superb.



researcher): Do you think it was the whole package of care that helped, that allowed [key person] to progress so well?

father): Oh, yeah, definitely, right from when she went into the hospital. The people in there were very kind, because it's not the best place to be, you know it's a very sad place to be obviously and you have to feel for the people that in there on a daily, weekly basis or monthly bases. But right from there she came out, she started seeing the doctors, [family worker], it was a real team effort and I can't thank them enough you know because without that input from everyone, and you know they were on the end of the phone if you needed them, they've been absolutely tremendous, absolutely tremendous. I am over the moon with what happened and the people who were there for us, we really needed them and they were really there for us. And they never ever let us down, you know it was 100% from them. And I'm hopeful, I hope it never happens to us again. But if it ever happens to someone, I sympathise for them but there is help. There is help. I can only see good in this occasion because every week [family worker] came up here and sat with us, spoke with us and targets to do and try and meet. But I think the whole thing is talking.

researcher): Talking was the key?

father): The communication, definitely, the way you speak to people.

researcher): And what effect do you think it had?

father): Well I think now it's so much nicer, if somebody says 'please' and 'thank you' because it costs nothing. Through life it costs nothing. mean I run a company and right through to the apprentice or the manager it costs nothing. To be nice. And if your nice to people normally they're nice back. But you must communicate.

researcher): So communication has opened things up?

father): I think the key to the whole thing is to be able to talk to each other and bring things out in the open and clarify what's happening and what's going to happen. And I think the idea of the family meeting was superb. And we would have never thought it before because we didn't know, but when we were taught it was like putting the light on. 's much, much better and we used to do the family meeting, sit down, is there any problems... "How you feeling? Have you been doing this? Have you got a problem? What are your thoughts?".

] help started in hospital
hospital staff very kind hard place
sympathy for other pts in hospital
FW support after discharge team Dr & FNs support after discharge team,
much gratitude to team
team back up phone support tremendous
team really there for us, very satisfied with treatment given,
team gave 100%
dad hopefullly of no relapse
if relapse help is available
FW came every week sat with us
FW not taught to do but talking more

] pleasant communication makes things
saying please & thankQ costs nothing

] if you're nice they're nice com is a

] idea of SFM superb

] would have never thought of SFM as i, intro of SFM like putting on the lig,

] talking bring things out in open, clarify whats happened % going to h,

] SFM talk about feelings (make a thought)

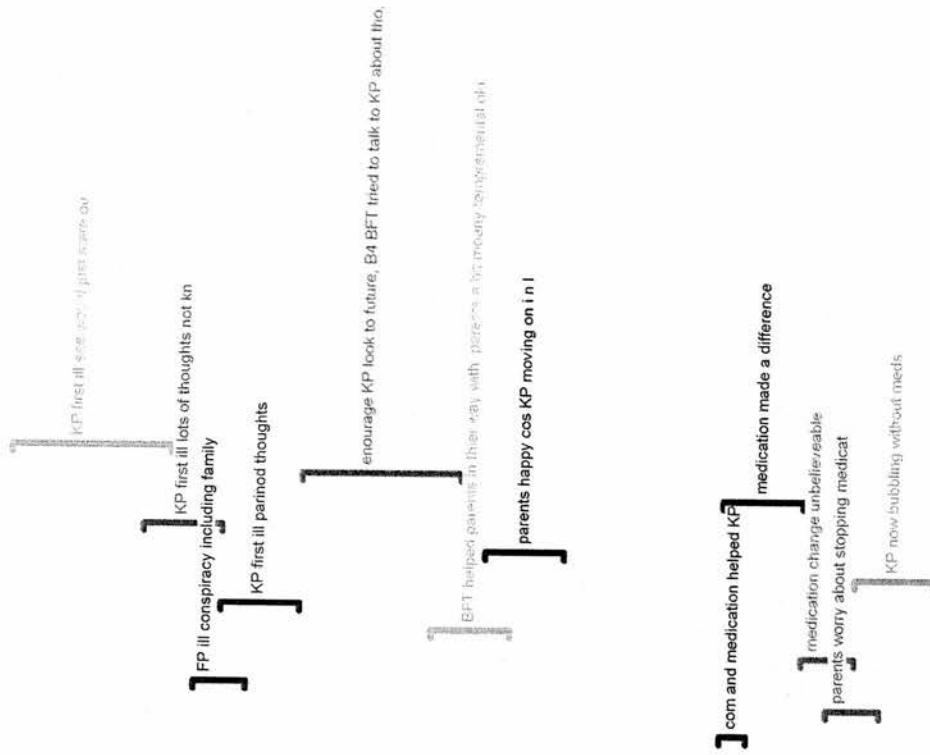
researcher): What was it like in the family meetings opening up thoughts that you hadn't shared before?

Father): I think the emotional side, because what happened when [key person] was first ill, she would sit here with her thoughts and I was in work and obviously I would come home to see if she was alright. And she would say 'where you going dad' and I would say you know 'I've got to go to a site somewhere', 'can I go with you?' and she used to go with me in the car and she used to just sit and stare. So obviously lots of thoughts there, what's going on? Because she didn't even realise that she was ill, because the whole thing was a conspiracy, and everybody was this, me, the wife was in this, everybody. If we were talking here now, if she was like she was before, she would be thinking we were talking about her. So I used to watch her in the car, she used to just sit...miles away. And when we got her home we used to just say 'what you thinking about' and try and get what her thoughts were, there is she going with them, is it the ex boyfriend, was it...you know. Trying to bring it out to really reassure her to say these things are there, and the future is here for her now and not the past. To go ahead and build a new life. And I think really because you know, we're a bit der that myself and the wife, temperamental, we're a bit moany groany, I think it's helped us a lot in our own way with her. Because obviously we're a lot happier because [key person's] happier and she is getting a new life and she's going forward and that's what we want to see.

researcher): Do you think the open communication helped when she was so stressed and unwell...helped her? helped her move on?

Father): That helped a lot and then they changed her medication, they gave a little white tablet, I can't remember what it was called now. And that made a difference like that. It was change in medication and we then it instantly. I called it the magic tablet, it as a little white tablet, the change in her was unbelievable. Our worry was what's going to happen when she came off the medication what's going to happen. But she's on no medication now and she's still bubbling and you know it's absolutely...I can't say enough how well she's doing you know

researcher): It does sound like it.



father): And I'm saying...again I go back to the team effort that was
mmm, all the people that was there to help and it did help, by talking to
s, by coming and talking to myself and my wife.

researcher): What effect did it have?

father): It had the effect in the sense where we were sort of way up
there, taut with everything. It made us more relaxed and reassured
ourselves that things will get better and where we can't say 100% that
it's a one off, it could be a one off and it may never happen again. And
we had the belief that this was a one-off, it was a belief in what we
were being told that this is a one off and it may never happen again.
You can't guarantee that of course, but we had to go with that belief
that we'll get through this.

father): So having that belief, what did that mean for you?

researcher): Well it helped in our minds that it may be a one off,
because we know that there are no guarantees in life of anything but it
did help to believe that it will get better. I mean what we've been
rough in the last few years...traumatic times. I died, I was in the
back of an ambulance and had to be brought back to life, so after that
you know you think there is something, if it's not your time it's not
your time. And you have to look forward and not back... What's happened
our lives, we're still smiling but I think now after that period in
r life which was a real, real hard period and it's umm really, really
better. The last year it's been unbelievably better and we're
joying each other as a family. You know when [key person] left home,
thought oh she's away from home, we changed her bedroom into a dining
room. We've had to change it back now because you know she did come back
me but umm she's home, she loves being here and we love her being here.
mean she's gone through that period in her life and now she'll end up
tting married at some point, settling down and having the grandchild
pefully...more grandchildren

researcher): So that's your new targets now

ather): Well it should be her target to meet somebody nice, I keep
trying to explain to her, you know there's somebody out there for her.
u'll bump into somebody one day, you know, you won't expect it, you'll
lk round the corner and booff it will happen, so be patient. She goes
wn...to my oldest daughter, I've been married twice so I've got another
ughter and a son and f
ve grandchildren so, she goes down and she watches the kids.

team talking to us, improvement due to team effort,

team involvement reassuring

belief that one off episode

belief of one off episode belief can

helped to believe in things getting

no guarantees in life

traumatic few years

dad suffered heart attack look forwa

smiling about life now hard few years

now enjoying each other as family

parents weren't expecting KP to move

KP & parents love living in family h, KP & parents love living together,

dad can see good future for KP

dad encourage KP to meet someone spec

and she goes out with sister and when we're away on holiday, my oldest
advised, he'll phone her up and invite her for her tea. So she's got...and
obviously they know what she went through, especially my older daughter,
she knows how difficult it's been so she looks after her.

(researcher): Can I ask about your views on if the family work has
affected the relationships within the family?

(father): It changed the relationships because we communicated a lot more
instead of the routine you get into, you get up in the morning, you go to
work then you come in and you watch the tele and not a lot happening.
Now a lot of the time the tele will go off and we'll talk. Today because
[wife] was off so she called up, my office is only 10 minutes away,
well come on, we'll go down to the garden centre and have a coffee".
[key person] and [wife] do quite a lot together, there's a lovely we bit
down there so they go and have a cake and have a cup of coffee and a blather
and away back to work. Yeah but I think it's helped us communication
better and more.

(researcher): And that seems to have had a knock on effect on other things

(father): It has really and I think [key person] doing her course she's
as well, it's brought her and [wife] closer because she's helping
you know to explain things to her, because she's doing projects, how
set things out, and work on the computer together, it's great. [key
person] normally comes to the office most days for a coffee, but a year
ago she would come to the office she wouldn't talk to anyone, she's
come right into my office and sit down and have a coffee but now she'll
come in and talk to my staff, I mean 'do you want a coffee' 'do you want
to make a coffee' and that's the difference. What a difference in her,
we'll come in a chat away to [office employee], who's my senior staff,
all see the difference in her, she comes in and chats away. Before
we would just nod and walk away and now she'll chat to you. So that's
the difference, she's actually communicating.

(researcher): So the open communication, do you think it boosted her
confidence?

(father): Yeah, 100% she's never ever been a confident girl, right back
from school days, but now she is confident and she'll chat away and
that's the big difference of it. Because she went through a big
operation herself, she had a double curvature on her spine and she had to
t that corrected so that was a massive operation when she was 15, and
again that was a stressful time because will she

other family members supportive of K

breaking habits of work home tele changed relationships more time talk

spending time together eg coffee

BFT helped more & better com

mum helping KP with work bring the 2, mum helping KP with work bring them,

KP now more talkative to others

others have noticed positive change

KP come out of self big difference

KP increased confidence

past stress KP had operation in teen

Appendix VII

Development of analysis

Development of analysis

This appendix provides examples of development of themes, subcategories and core categories and is divided into beginning, middle and end phases of analysis. Figure 1 is a diagrammatic representation of the three stages of analysis with corresponding coding and data collection stages.

Beginning phase of analysis

The interviews conducted at the start of the study represented the beginning of the process of exploring the experience of BFT. In this early phase, there were no pre-existing themes or categories. Interviews were conducted and then transcribed verbatim by the researcher. Following this, transcripts were re-read and line by line coding was generated by the researcher using NVivo 2 software.

As described in the method (section 2.2.7), this marked the first stage of coding, ‘initial coding’ (Charmaz, 2006), in which lines or sentences of transcripts were given descriptive labels to summarize their possible meaning (cf. appendix VI: transcript extract with initial coding). Examples of initial codes from interviews 1 and 2 and interviews 7 and 8 are presented in table 1.

Figure 1: Stages of analysis

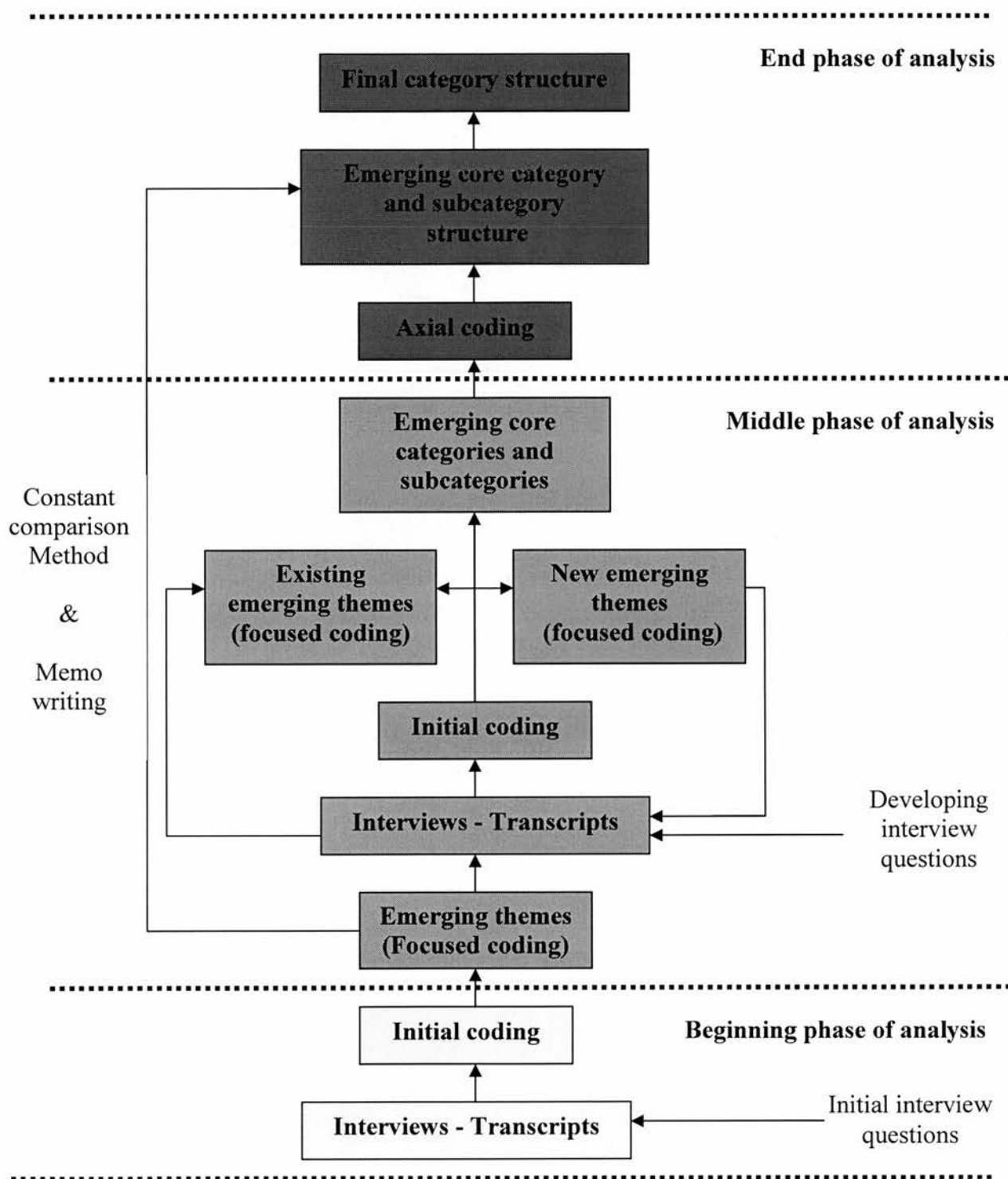


Table 1: Example initial codes (interview 1 and 2; interviews 7 and 8)

Initial codes - interviews 1 and 2	Initial codes - interviews 7 and 8
Arguments with sister	Working more as a team
Improved relationship with sister	Realised took her for granted
Better interaction – saying thank you	Looked forward to seeing family
BFT highlighted illness	Not good at expressing ourselves
Less confrontation	Doing more together
Avoiding each other	Frustration with illness
Initial reject of BFT	Saying please, thank you
Realisation of importance of family	Constant arguments in the house
Accepting criticism	Talking in structured family meetings
Problem solving	Family worker outside looking in
Nervous about family worker coming in	Tiptoeing around problems
Not contents of sessions but space	Key person doesn't like focusing on illness
Highlighted need to support each other	Discussing what to do to resolve arguments
Doing more around the house	Learning to listen more
Impact of medication	Breaking down arguments
Not cause and effect	Better ways to communicate
Directly dealing with illness	Family worker easy to talk to
Committed to process	More time talking
Subtle differences in communication	Immediately saw benefits
Support of MDT	Quality family time

Middle phases of analysis

The second stage of coding 'focused coding' (Charmaz, 2006) was started after three interviews had been conducted and coded (generating initial codes). As described in the method (section 2.2.7), the researcher wrote memos about salient initial codes, questions arising from the initial codes and possible relationships between them. Memos were written

in freehand as a method of recording and tracking the researcher's thoughts and ideas as she had them. From these memos, the first emerging themes (focused codes) were generated.

Charmaz (2006) suggests that in focused coding the researcher must make tentative decisions "about which initial codes makes the most analytic sense" in order to begin to categorise the data (p58). The researcher based her decisions about which initial codes represented the most salient themes to be developed into focused codes on several factors:

- Aspects of the experience of BFT that participants directly highlighted as important
- The most frequently raised topics within each participants' experience.
- Noticeable similarities and differences between participants' experiences.
- Less prominent topics of discussion, which the researcher tentatively designated as important in understanding the experience of BFT and which therefore warranted further investigation.

Examples of early memos and corresponding emerging themes (focused codes) are presented in table 2.

Table 2: Examples of memos and corresponding emerging themes (focused codes)

Memo	<p>Participants spend a lot of time talking about communication. They described discussing communication styles in BFT sessions as a useful strategy in helping them resolve problems and arguments. All three expressed that communication was a very important aspect discussed in BFT. Communication was also discussed in terms of generally speeding more time together, this theme seems important and wider than just a tool used in problem solving.</p> <p><u>Development of emerging theme (focused code): ‘communication styles’ in problem solving</u></p>
Memo	<p>Participants regularly raised the issue of conflict/arguments within the family. All three described a tense atmosphere in the home and viewed BFT as having a direct impact on improving the atmosphere at home.</p> <p><u>Development of emerging theme (focused code): ‘family conflict’</u></p>
Memo	<p>Participant 2 seemed to stress that BFT was only one aspect of the key person’s treatment and this seems important in her evaluation of the effects it had. Participant 1 (key person) also discussed the various medications he was currently on which he felt were directly effecting his mood. He did not view BFT as having an effect on his illness. This would be important to discuss with other key persons to see if they shared the same views.</p> <p><u>Development of emerging theme (focused code): ‘BFT integrated with other treatments’</u></p>

In the early stage, emerging themes remained very closely linked to the initial codes, often taking on a similar or identical descriptive label. The similarity between initial coding and emerging themes reflected an attempt by the researcher to keep as close to the data as possible, in an effort not to misinterpret the data and therefore skew later analysis.

Emerging themes from the first three interviews were used to develop interview questions for subsequent interviews (cf. appendix IV: interview schedule). Initial coding and further focused coding were conducted in subsequent interviews (interviews 4 to 8) to allow new emerging themes to be generated and carried into further interviews (interviews 9 to 15). Therefore, the processes of initial coding, memo writing and focused coding were conducted in parallel.

Using the ‘constant comparative’ method (Glaser & Strauss, 1967), initial codes were compared to each other and to each emerging theme (focused code). This allowed related initial codes to be structured together under an emerging theme. From this, emerging themes were refined to approach a more analytic understanding of the experience of participants. As the researcher moved through the analysis of transcripts, themes were at times revised to refine representation of the initial codes, allowing the researcher more confidence to develop early emerging themes into the final themes presented in the results section. Table 2 presents the development of the structure of example emerging themes and corresponding example initial codes from interviews 1 and 2.

As focused coding and memo writing continued (table 3 presents examples of memos at later stages of coding), emerging themes were further analysed to identify tentative relationships, similarities and differences across participants’ narratives. Themes that were interpreted by the researcher as the most salient in understanding the experience of BFT were raised to subcategories. Data was further structured by re-reading and organising similar or related emerging themes together under subcategory labels. The labels given to

subcategories again marked a further move towards analytic understanding of the experience of BFT, as opposed to a direct description of it as was the case with the initial codes. This process was similar to the process of grouping similar initial codes into emerging themes and served to reduce the data into meaningful groups.

Table 2: Emerging themes (interviews 1 and 2) with corresponding initial codes

(Emerging) Theme	Initial code (interviews 1 and 2)
Conflict/arguments	Arguments with sister Less confrontation Avoiding each other Improved relationship with sister
Communication	Better interaction – saying thank you Subtle differences in communication
1 st impression of BFT	Initial rejection of BFT Nervous about family worker coming in
Commitment	Committed to process
Importance of family	Realisation of importance of family Highlighted need to support each other Doing more around the house
Accepting criticism	Accepting criticism
Problem solving	Problem solving
Therapeutic space/safe space	Not contents of sessions but space
Not cause and effect	Not cause and effect Support of MDT
Medication	Impact of medication
Focus on illness	Directly dealing with illness BFT highlighted illness

Table 3: Examples of memos written in the later stages of coding.

Memo	<p>Initial codes such as ‘walking on eggshells’, ‘tiptoeing around problems’ and ‘not good at expressing feelings’ seem to revolve around the participants’ fears of psychosis (both key persons and other family members). These codes suggest a key contributing factor in tension and causes of arguments. This avoidance was described as present before BFT but it seems important as participants described that they were able to explicitly identify these avoidant behaviours in BFT sessions.</p> <p><u>Development of emerging theme (focused code): ‘Avoidance’</u></p>
Memo	<p>Participant narratives placed emphasis on the importance of therapeutic space and the relationship with the family worker. Participants all described the family worker in glowing terms which appeared to help them engage with the process. Several participants directly expressed that they remembered the supportive atmosphere of BFT sessions more than the content of what was discussed.</p> <p><u>Development of emerging subcategory (focused code): ‘therapeutic atmosphere’</u></p>
Memo	<p>The theme ‘positive experience’ appeared within all narratives and in most it was emphasised. This seemed to be a key shared experience. Linked to this evaluation of BFT a positive seemed linked to the wider context of BFT with participants placing BFT as one treatment within a wider package of care (theme ‘integrated with other treatments’).</p> <p><u>Development of emerging subcategory (focused code): ‘evaluation of BFT’</u></p>

At the same time, new interviews were conducted and coded. Initial codes from these interviews that related to existing emerging themes and subcategories were organised directly into the existing theme and subcategory structure. Initial codes that described new experiences allowed for the development of further emerging themes. Many themes that

would later be developed into categories and subcategories emerged early in the interview process and this was noted in the reflective diary.

The researcher attempted to assess the relationships between the themes and subcategories and the processes involved in them by asking questions of the data such as:

- What actions were participants describing?
- What was involved in the behaviours participants were describing?
- What processes were involved?
- What connections were participants making between different aspects of their experience of BFT?
- What are the differences and similarities between participants' experiences?

Table 4 presents examples of the development of the structure of subcategories and emerging themes (using some of the initial codes shown in table 1). To illustrate the progressive development of the structure, initial codes from interviews 7 and 8 are highlighted in blue, whilst new emerging themes and 'new' emerging subcategories are highlighted in red.

Table 4: Example of the development of themes and subcategories.

(Emerging) Subcategory	(Emerging) Theme	Initial code
Reduction in conflict	Conflict/arguments	Arguments with sister Less confrontation Constant arguments in the house
Avoidance	Avoiding each other	Avoiding each other Tiptoeing around problems Not good at expressing ourselves
Communication	Expressing appreciation Increased communication	Better interaction – saying thank you Subtle differences in communication Saying please, thank you Better ways to communicate Talking in structured family meetings More time talking
Engagement	Immediate potential Commitment to process	Initial reject of BFT Nervous about family worker coming in Immediately saw benefits Committed to process
Family support	Family team-work Giving/receiving support	Realisation of importance of family Highlighted need to support each other Doing more around the house Working more as a team Realised took her for granted
Problem solving	Accepting criticism Problem solving Active listening	Accepting criticism Problem solving Breaking down arguments Discussing what to do to resolve arguments Learning to listen more
Therapeutic atmosphere	Therapeutic space/safe space Positive towards family worker	Not contents of sessions but space Looked forward to seeing family worker Family worker easy to talk to
Time spent together	General time together	Improved relationship with sister Quality family time Doing more together
Evaluation/context of BFT	‘Not cause and effect’ & ‘medication’ revised to ‘Intergrated with other treatments’ Perceived effect on psychosis	Not cause and effect Support of MDT Impact of medication Frustration with illness
Family focused	‘Focus on illness’ ‘Focus away from illness’	Directly dealing with illness BFT highlighted illness Key person doesn’t like focusing on illness
Family worker as teacher	Outsider perspective	Family worker outside looking in

The process of refining and developing emerging themes and subcategories continued as subsequent interviews were conducted. After 15 interviews, initial codes generated appeared to 'fit' within the existing structure, with no new emerging themes being generated. This is understood in grounded theory as reaching the point of 'saturation'.

Four types of themes were noted in relation to the experience of BFT. Firstly, themes that the researcher interpreted as directly related to the experience of BFT sessions: for example, 'engagement' with BFT, 'gaining information' about psychosis, 'problem solving' strategies discussed and practised in sessions, 'looking inwardly', which refers to participants' self-reflection in sessions, and 'positive experience' of BFT.

Secondly, themes the researcher interpreted as indirectly related to the experience of BFT sessions, which concerned experiences outside of sessions or before and after the completion of BFT. These themes focused on experiences of perceived changes occurring as a result of BFT. Examples included 'reduction in conflict', 'increased communication', 'general time together' and 'giving support'.

Thirdly, themes that were not related to the content of BFT sessions but were interpreted by the researcher as important to the understanding of the experience of BFT; for example 'integrated with other treatment', placing BFT in its context of being received alongside other treatments and 'knowledge' of psychosis held by participants before BFT, which therefore impacted on the amount of information given about psychosis within sessions.

Fourthly, themes interpreted by the researcher as experiences of participants not affected by BFT. A key example of this is the theme 'perceived effect on psychosis', where some participants perceived that BFT had not affected their experience of illness.

Charmaz (2006) emphasises the crucial role that language plays during coding and throughout analysis, in terms of the language used in participants' narratives and the language used by the researcher in labelling the meaning of sections of narratives. Within this, no researcher can remain neutral, as language is part of the social context of the speaker. Therefore, the final analysis must be viewed as the researcher's engagement with the narrative presented by the participants during their interaction with the researcher.

End phase of analysis

The end phase of analysis aimed to bring together sections of meaning (in the form of subcategories and themes) into a coherent whole (Charmaz, 2006). As described in the method (section 2.2.7) 'axial coding' (Strauss & Corbin, 1990; 1998) was used to organise and identify the properties emerging core categories, subcategories and themes to recreate a representation of participants' experience of having received BFT. Charmaz (2006) suggests that axial coding aids the development of an emerging core category, while allowing a flexible approach to refine the final categorisation.

This involved an active process of re-reading themes and categories and tentatively grouping related subcategories together into wider analytic categories, labelled as core categories. A large part of this final stage of analysis was done by hand. Paper labels of

themes and subcategories were used to experiment with different structures and potential groupings.

Draft diagrams connecting themes and subcategories were drawn to aid this process, as this allowed different relationships to be tested out. The researcher again used the 'constant comparative' method (Glaser & Strauss, 1967), checking themes and categories against each other to allow a true or accurate representation of participants' experience of having received BFT.

For examples, the emerging subcategories, 'identifying problems' within the family, 'understanding' psychosis and 'problem solving' were interpreted by the researcher as related to a wider category of problem management and conflict management. From this, a core category 'conflict & problem management' was generated (see results section 3.2.2). The emerging subcategories 'time spent together', 'family support' and 'communication' were interpreted by the researcher as related to the concept of the family unit and were grouped together under the core category 'family togetherness' (3.2.3).

The theme 'communication' was prominent in participants' narratives. Within this, aspects of communication such as 'increased amount of communication' and 'expressing appreciation' were interpreted by the researcher as dominant in the experience of 'family togetherness'. Alongside this, aspects of participants' experience of enhancing their communication style were related to problem solving strategies utilised in BFT. Thus, a decision was taken to organise the theme 'communication styles' within the subcategory

‘problem solving’ (core category ‘conflict & problem management’); and to organise the subcategory ‘communication’ within core category ‘family togetherness’, reflecting its influence within the category.

Appendix VIII

Local Research and Ethics Committee approval letter

Telephone:
Fax:

Local Research Ethics Committee 02

Telephone:
Facsimile:

08 February 2007

Miss Alina A Galis
Trainee Clinical Psychologist

Dear Miss Galis

Full title of study: It's a Family Affair: Qualitative investigation into families' experiences of receiving Behavioural Family Therapy for Psychosis V1
REC reference number: 06/S1102/53

Thank you for your letter of 10 January 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 07 February 2007.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	5.2	10 January 2007
Investigator CV		
Protocol	2	10 January 2007
Covering Letter		15 December 2006
Letter from Sponsor		01 November 2006
Letter of invitation to participant	1	15 November 2006

GP/Consultant Information Sheets	1	15 November 2006
Participant Information Sheet: Participant	2	10 January 2007
Participant Consent Form	1	15 November 2006
Response to Request for Further Information		10 January 2007
Insurance Details		28 July 2006
Family Referral Form	1	15 November 2006

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/S1102/53

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

**Professor
Chair**

Email:

Enclosures:

*Standard approval conditions
Site approval form*

Appendix IX

Local Research and Development Department approval letter

University Hospitals Division

Research Institute

1st March 2007

Miss Alina A Galis
Trainee Clinical Psychology

Dear Miss Galis

MREC No: N/A
CRF No: N/A
LREC No: 06/S1102/53
R&D ID No: 2007/P/PSY/04
Title of Research Its a Family Affair: Qualitative investigation into families experiences of receiving Behavioural Family Therapy for Psychosis V1
Protocol No/Acronym: N/A

The above project has undergone an assessment of risk to NHS [redacted] and review of resource and financial implications. I am satisfied that all the necessary arrangements have been set in place and that all Departments contributing to the project have been informed.

I note that this is a single centre study sponsored by **University of Edinburgh**.

On behalf of the Chief Executive and Medical Director, I am happy to grant management approval from NHS [redacted] to allow the project to commence, subject to the approval of the appropriate Research Ethics Committee(s) having also been obtained. You should note that any substantial amendments must be notified to the relevant Research Ethics Committee and to R&D Management with approval being granted from both before the amendments are made.

Please note that under Section A, Q35, NHS [redacted] provides indemnity for negligence for NHS and Honorary clinical staff for research associated with their clinical duties. It is not empowered to provide non-negligent indemnity cover for patients. NHS [redacted] does not provide indemnity against negligence for healthy volunteer studies. This is the personal responsibility of both NHS and honorary employees and is usually arranged with a medical defence organisation or through the University of Edinburgh.

This letter of approval is your assurance that NHS [redacted] is satisfied with your study. As Chief Investigator or local Principal Investigator, you should be fully committed to your responsibilities within the Research Governance Framework for Health and Community Care, an extract of which is attached to this letter.

NHS

RESEARCH & DEVELOPMENT OFFICE

Tel: [redacted]
Fax: [redacted]
Email: [redacted]

Director: [redacted]

R&D Governance Manager [redacted]

Commercial Research
Manager: [redacted]

Research Manager Capacity &
Capability: [redacted]

Research Governance
Co-ordinator: [redacted]

Information & Knowledge Manager [redacted]

AHP Research & Development
Facilitator: [redacted]

Accountant: [redacted]

Assistant Accountant: [redacted]

Trial Support Officer: [redacted]

Office Manager: [redacted]

Administrative Assistant: [redacted]

St John's - Administrator: [redacted]

Yours sincerely

[Redacted signature]

Professor
R&D Director

Enc	Research Governance Certificate	<input checked="" type="checkbox"/> (to be signed and returned)
	NRR authorisation	<input checked="" type="checkbox"/> (to be signed and returned)
	Tissue Policy (if applicable)	<input type="checkbox"/>
	MTA (if applicable)	<input type="checkbox"/> (to be signed and returned by the recipient)

Copies Administrators, Research Ethics Committee

[Redacted list of recipients]

Appendix X

Consent form

CONSENT FORM

Understanding Families' experiences of receiving Structured Family Work

(please tick)

I have read and understand the Project Information Sheet, been given an opportunity to ask questions about the project and have received satisfactory answers to all my questions.

Yes ☐

No ☐

I understand that my participation in the project is entirely voluntary and that I am free to withdraw my participation at any time without needing to give a reason. I understand that if I choose to withdraw from the project, this will not affect any present or future NHS care I or my family may receive.

Yes ☐

No ☐

I give consent for the interviews I participate in to be audio-taped and then transcribed onto computer.

Yes ☐

No ☐

I give my consent to participate in this project.

Yes ☐

No ☐

I would like my GP to be informed of my participation in this project

(please tick)

Yes ☐

No ☐

If yes, please provide the name and address of your GP:

.....
.....
.....
.....
.....
.....

I would like to receive a summary of the results of the project when it is complete

Yes ☐

No ☐

If you are under 18 years old:

Your Name.....

Parent/Guardian name.....

Your signature.....

Parent/Guardian signature.....

Date.....

Date.....

Researcher signature.....

Name..... Date.....

Appendix XI

Participant demographic information

Participant demographic information

Table 1: Demographic information of participants

	No. of families = 5 No. of individuals/ interviews = 15	Mean age in years (range)/ Male/Female ratio
Interviewees		
Key person	4	(M:F; 2:2)
Mothers of key person	4	
Fathers of key person	3	
Siblings of key person	3	
Partners of key person	1	
Ethnicity		
White	12 (4 families)	
Black African	3 (1 family)	
Received BFT following:		
1 st episode/2 nd episode	2	20.6 (18-25)
multiple episodes	2	45.5 (43-48)
Length of time since completed BFT		
> 6 month	3	
> 18 months	2	
Key person living with:		
Family	4	
Spouse/partner	1	
Diagnosis of key person:		
Paranoid schizophrenia	2	
Psychosis	2	